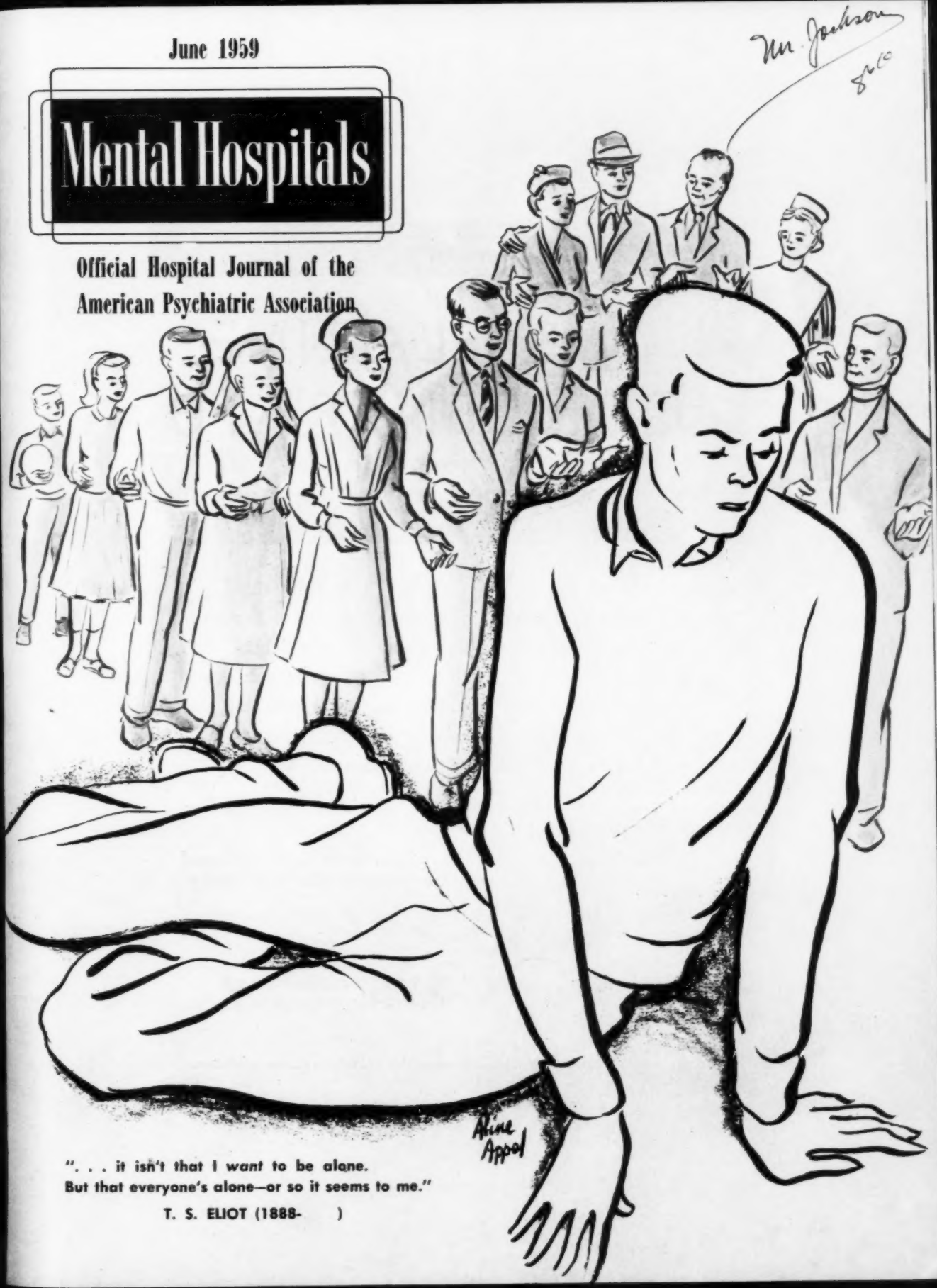
June 1959

Mental Hospitals

Official Hospital Journal of the
American Psychiatric Association



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Mental Hospitals

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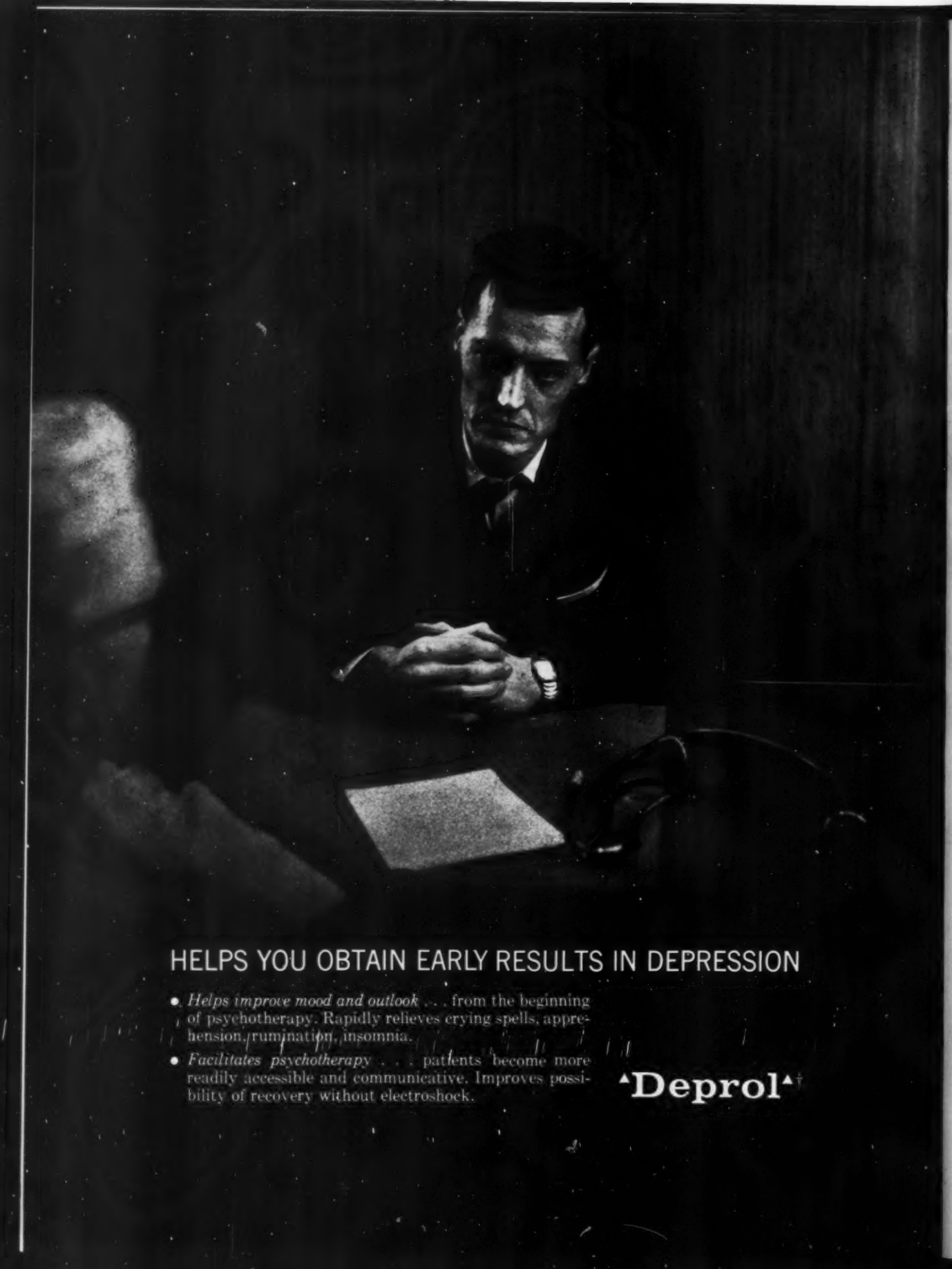
OFFICIAL HOSPITAL JOURNAL OF THE AMERICAN PSYCHIATRIC ASSOCIATION

CONTENTS, JUNE 1959

MENTAL HOSPITALS offers a forum for free discussion about matters of interest to persons involved in the care and treatment of psychiatric patients. Opinions expressed by the authors are theirs and do not necessarily represent the official policy of the American Psychiatric Association.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PROFESSIONAL Feature Of The Month

Nursing Care of the Geriatric Patient

By NELL T. BALKMAN, R.N.
Instructor in Psychiatric Nursing
VA Hospital, North Little Rock, Ark.

THE FACTS THAT PSYCHIATRIC illness is the largest single cause of chronic infirmity in senescence, and that 25% to 30% of the total number of admissions to mental hospitals are patients over the age of 60, should move our nursing profession to positive thinking, planning and action. It seems important, therefore, to understand the factors contributing to the problems in nursing care of geriatric psychiatric patients, and to formulate some positive plans.

If we desire to meet the impact of problems encountered each day on a psychiatric unit for the aged, then the foundation must be built on knowledge of this age group, based on scientific research and its implications for nursing. The inseparability of the psyche and the soma must be understood in relation to the person's physical, mental, emotional, and socio-economic experiences. How can personnel work intelligently and take a hopeful approach if this basic knowledge is missing? Knowledge leads to understanding of the needs of the mentally ill geriatric patients as individuals and as a group. This is the crux of nursing care.

Do we see the patient's needs from his point of view, or from our own social standards of acceptable and non-acceptable behavior? Regardless of the patient's behavior, it comes as a result of his needs. The behavior manifestations of forgetfulness, confabulation, confusion, disorientation, and refusing to eat, are superficial. Too often we accept superficial behavior and do not seek the reasons for it.

Do we not, for instance, create or add to the necessity of feeding many patients by the way we start out in the morning? We literally sweep them out of our way for the day when we start sweeping, mopping and making beds before breakfast. Would personnel survive the shock of serving coffee, tea or fruit juice at the bedside table and allowing the patients time to enjoy this beverage in an unhurried atmosphere before they dress? It must not be forgotten that the tempo of the unit is determined by the attitude of the personnel. Is not morning the time to slow down the tempo for the benefit of the patients? These elderly people must have time—and we must have patience. The way we start the day will determine their dependence or independence.

There are few, if any, geriatric psychiatric patients who do not have potentials for improvement if personnel will take the time to establish proper interpersonal relationships, verbal and non-verbal. We often fail in this area by not giving our patients credit for having any awareness of their limitations or disturbances and how these motivate their behavior. These patients have a keen awareness of the areas in which they are failing, such as memory, judgment, orientation, liability, but they still have the right to their defensive mechanisms of trying to adjust. The ingredient that we can use to facilitate these adjustments is attention to the small comforts of the patient.

How often are we guilty of saying: "John, you are making a mess!" "Now, look at your shirt!" "You are just like a baby!" "Look at the food on the tablecloth and floor!" "You can't have your dessert unless you eat your other food." John will either become agitated and blow what food you have put in his mouth all over you, or will succumb to being fed. On all accounts you have reduced him to the psychological level of an infant.

First of all, he is not John—he is Mr. Jones. He is your senior by many years and deserves by your respect to be recognized as such. Did you consider why he might be making a mess? Is this his own place to eat each meal? Or does he take the place that is left because he can't walk as fast as the others and you think he is so disoriented he wouldn't recognize his place at the table? Did you consider he might be uncomfortable because he was not assisted to the bathroom before mealtime to void, and wash his hands and face? Is it possible you have failed to observe that he might need dental care? Referring to the food on the tablecloth and floor is saying, "You are in the way and I'm going to have to sweep and mop." Withholding the dessert is exercising your authority and it is a threat. We must approach feeding problems without preconceived social evaluations.

Staff Often Responsible for Feeding Problems

For the most part we are responsible for many feeding problems. A prevalent and most unfortunate misconception is that feeding problems start abruptly at some certain meal. Nothing could be further from the truth. They start days or weeks before, from a complex multifaceted phenomenon of the interaction of an organically ill personality and his environment. His reaction to refuse food is, therefore, motivated. To understand this motivation will call for thoughtful consideration and observation of personnel on all tours of duty.

The doctor and the nurse frequently fail to realize that the same words may often mean many and quite different things to different people. "Motivation" and "awareness" to the doctor and nurse, for instance, may

constitute a therapeutic outlook; but do they for all personnel? How do you know that they do? If the nurse says the doctor would like us to motivate Mr. Jones to go to the bathroom because he is aware of the fact his trousers are wet, does this convey to the personnel that Mr. Jones deliberately soils his clothes, is stubborn, and could stop? Or does it convey that Mr. Jones needs the kind of support that might make it unnecessary for him to be incontinent by anticipating his need to go to the bathroom, and that this should be our attitude toward him? "The operation that distinguishes nursing care from the care of any other helping profession is its ministrations—doing for a patient that which he would do for himself but is unable to do for a time or for all times; performing these nursing measures of personal and mental hygiene as he would if he were able."*

Specific Duties Desirable for All Patients

One thousand of our patients fall within the range of geriatric psychiatric care. We find it highly desirable to develop the idea within each unit that nursing care should be particularly concerned with personal relationships. Every patient who is capable has a job to perform, no matter how simple the task, and personnel should give him recognition for his usefulness and achievements. His job may be to push another patient's wheel chair to the dining room, assist in feeding, oral hygiene, changing clothes, dusting a chair, planning a committee for a party, organizing a decoration or an invitation committee, caring for the flower boxes, birds or fish. Some patients are unique in their accomplishments. There is the patient who meets you as you enter the unit, introduces himself, greets you as if you were in his home, looks around the ward and says, "Now, let's find you a chair. I want the other men to meet you. What is your name again, please?" Then he introduces you and asks the other patients to come and shake hands with you. He is aware that he does not remember the patients' names.

Superficially our feebler patients may seem incapable of taking part in any activities. But by accepting superficial behavior at its face value, we deprive them of the chance to channel their behavior constructively if we therefore fail to bring occupational and recreational activities to the ward. In our hospital setting we have found this to be a therapeutic measure. Under the guidance of the occupational therapist we maintain a cart equipped with materials suitable for the patients' capabilities. An example of the therapeutic value of this was demonstrated in a patient who would slap his face so rapidly and hard that it was necessary to restrain his hands. We watched diligently for what motivated the patient to slap himself, but in the meantime we asked his help in unraveling a sweater so the thread could be used for another project. He responded to this; he was aware of his covert feelings before they became overt, and would ask for his "raveling."

It takes time to create interest and to motivate these patients, but they will help you if you listen. One patient kept saying, "I can't do anything." I really think we thought so too, as he is confined to his wheel chair and has much difficulty coordinating his movements. One day when we were behind with our oral hygiene, he rolled his chair over and said, "I've found my job. If the girls will bring me a pan of water and towels, I'll have the towels ready three times a day." After three years he still prepares the towels for oral hygiene. Once he remarked, "When I die and go to Heaven, St. Peter will stop me and ask if I've had my mouth wash."

So nursing the geriatric patients in a mental hospital is not only the performance of skills and techniques; nursing care is the care of these people by the nurse who understands them, their motivation and behavior. "The use of this understanding throughout all her care to the patient's ultimate well-being, is an interaction operation, and it must be considered as one index in measuring the goodness of nursing care because it permeates all nursing operation. The criteria of performance, such as safety, comfort, therapeutic effectiveness, the economy of time, effort and materials, are all affected by the personal interaction." *

We will be working in a vacuum until the basic schools of nursing, the schools of practical nursing, and the inservice education programs recognize the field of geriatrics as an integral part of their curriculum. Too often the organization of the curriculum, the quality of teaching, and the educational climate are such that the area of geriatrics is used for learning nursing procedures such as giving an enema or a bath without any attention to basic principles, guiding principles, or nursing care principles of this period of life. This is not to say the area of geriatrics should not be used in learning nursing procedures. Unless the instructor's philosophy and objectives are dynamic, however, undesirable attitudes and lack of interest in geriatric nursing will result. This leads us to the realization that personnel working with the geriatric psychiatric patients must have special preparation to fully recognize the worth of each individual and his right to express his needs, and that there is for every patient an optimum level of comfort, satisfaction, and capacity for accomplishment in a mental hospital.

Recommended Staff Pattern for Geriatric Unit

Staffing patterns of geriatric units are often markedly below those required for good nursing care. This is especially true where patients are confined to wheel chairs and beds, and require comprehensive care in showering, bed baths, oral hygiene, dressing, undressing, feeding and general nursing care. In such areas one professional nurse for every fifteen patients, and one non-professional person for every four patients, over a twenty-four hour period would be considered adequate, assuming provisions are made for regular relief for the workday and work week according to established hospital policy. This should also include vacation time, holiday time, authorized sick leave, etc.

Translated into a daily staffing pattern for 100 patients, this would permit the assignment of six nurses on the day tour of duty, five nurses on the evening tour

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* *Kreuter, Frances Reiter:* "What Is Good Nursing Care?" NURSING OUTLOOK, *Vol. 5, May 1957.*

* *Ibid.*

of duty, and four nurses on the night tour of duty. For non-professional workers, it would mean ten on the day tour of duty, eight on the evening tour of duty, and seven on the night tour of duty. The over-all staffing pattern would be 20-plus nurses and 35 non-professional people.

The field of geriatric psychiatric care is overflowing and the laborers are few. This is not to propose that the entire answer to this problem can be found in increased numbers of personnel. But that this is a critical consideration is beyond question. Hospital administrators, doctors and nurses have labored long under the yoke of "we will do the best we can, with what we have." The "best," however, has ceased to be good enough for this age group in mental hospitals. To suggest an increase in personnel automatically flashes increased budget. Are the American people willing to invest more in the numbers of personnel caring for geriatric psychiatric patients? Upon this decision rests the future of many people who could be rehabilitated and returned to their families before the family ties are broken forever.

We as nurses have an inescapable responsibility to be leaders in guiding and teaching all who care for the person who is aging or aged, so that their philosophy and goals will blend with ours, thereby assuring to the aged population in mental hospitals, nursing homes or the community, their right to the very best that we as nurses have a privilege and duty to give.

The Release Bandwagon

By DR. WHATSISNAME

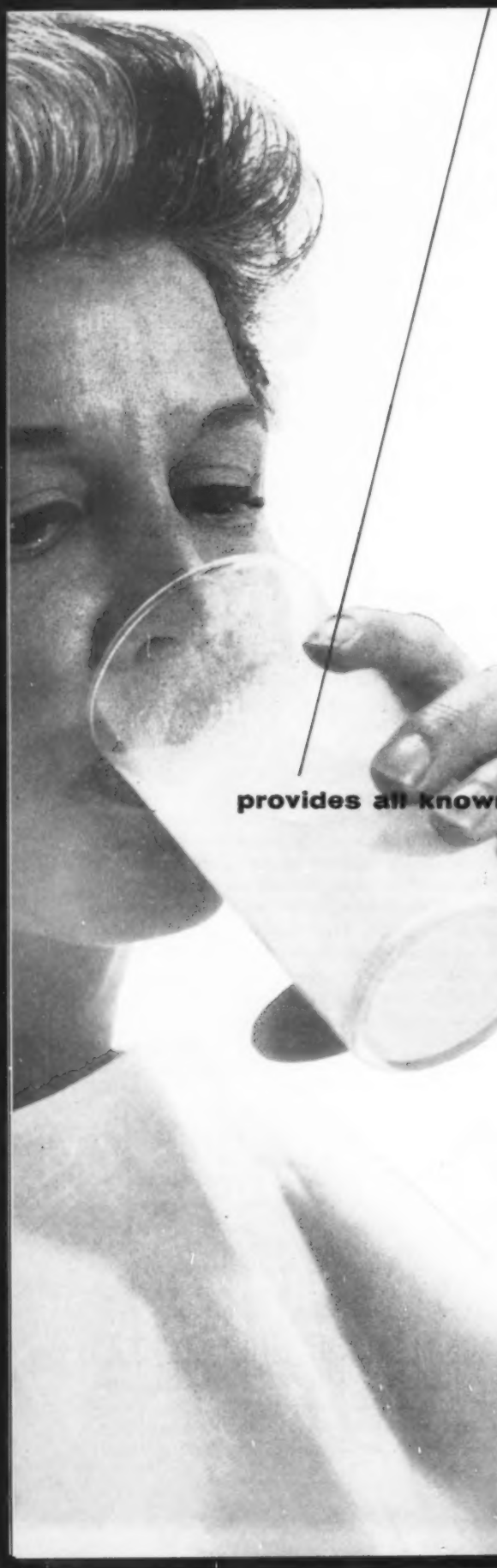
WE HOSPITAL PSYCHIATRISTS may be short of personnel, time, money and supplies. But we are never short of patients. So we are not afraid of going out of business when we speed up discharge rates.

The pressure, indeed, is the other way around. Everyone wants us to send patients out as rapidly as we can. Our staff wants it because it eases their burden and it suggests that they are competent workers. The legislators want it because it reduces hospital costs. Our friends in the mental health movement are delighted when the turnover tempo is whipped up, since this can be credited to their work. And the superintendent who can show a higher discharge rate this year than last year feels proud of himself.

There is a bandwagon effect here. If State Hospital X shows a 2 per cent drop in census, the board of State Hospital Z wants to know what's the matter with Z? And to show that he's just as good as Brother Y, the superintendent at Z decides to discharge more patients this year. The clinical director is told to tell the chiefs of service to comb through the wards. If a patient can wait on tables in the staff dining room, why can't he wait on tables in the town diner? If he cuts plants in the hospital greenhouse, why can't he work for a florist downtown? And the chief tells the medical officer in the infirmary ward that *his* patients are properly a charge on their relatives, so see how many can be returned to the family's care. Social service is urged to find more foster homes, jobs or boarding homes for quiet, ambulatory patients. By the end of the year, under this whip, hospital Z shows a commendable turnover.

This is such an enchanting prospect that we sometimes forget that we have other responsibilities. The premature release of a patient may be an evasion of such responsibilities. There are the rare but dramatic assaults, suicides, killings, and other explosive acts sometimes committed by ex-patients. More commonly, the prematurely released patient relapses so soon that his release becomes a mockery and justifies questions about the hospital's judgment. Or the patient may find himself lonesome and bewildered in a world he doesn't understand, and become a pathetic piece of flotsam in a sea of hostility. To the casual observer, work in the hospital laundry may seem no different from work in a commercial laundry. But the patient who crosses the bridge may find himself unable to compete in the open labor market. This could be frightening after the security of an institution where, even though the meals may not be good, at least you always know where the next one is coming from.

A few decades ago, the danger was that the patient would be forgotten as soon as the ward door was locked behind him. But today, when more and more ward doors stay open, the pressure is all in the direction of hasty release. There is a curious irony in this, for once the cry was that the patient was becoming just a number on a chart. And now, perhaps, the patient's human needs for security may be forgotten in our anxiety to put bigger numbers in the "discharged" column.



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The booklet "Therapeutic Nutrition: The Use of Food in the Management of Illness and Injury" is available on request from Mead Johnson, Evansville 21, Indiana.

1. Campbell, D. G., in Wohl, M. G., and Goodhart, R. S.: Modern Nutrition in Health and Disease, Philadelphia, Lea & Febiger, 1955, chap. 30., pp. 803-840.

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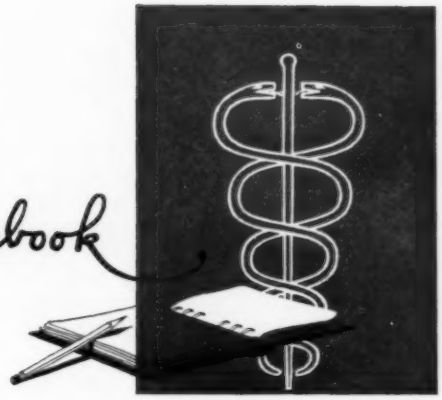
The Editor's Notebook



A FEW YEARS AGO an Englishman whose field was aircraft design and production came to the United States on a mission for his government. On his way home, he stopped off in Washington, D. C., and became involved in a discussion with friends as to why the British generally lead in design, whereas the American engineers are so far ahead in production. His reply, for what it is worth, is startling to an American. He said: "I believe it is because in England our universities produce a very few absolutely first-rate people, whereas your American universities produce a great many very good second-rate people."

Recently I was reminded of this story (which, incidentally, I heard from Pat Vosburgh) while reading an article by Eric A. Walker, President of the Pennsylvania State College, in the April 1959 issue of THE EDUCATIONAL RECORD, wherein Dr. Walker stated:

"The more serious (of these criticisms) . . . are those based on the assumption that in education, quality and quantity, like oil and water, do not mix. According to this assumption, we can choose to educate a few people exceedingly well or to educate a larger number somewhat less well, but we cannot do both. And, since we cannot do both, we must concentrate our energies and our resources on the education of an intellectual elite."

Dr. Walker, in developing his theme, "Quality in Quantity," goes on to spell out a number of other comments on our American educational system, and comes to this conclusion:

". . . We must develop an educational system that makes it possible for any American to become a first-rate something. We must have quality *and* quantity—a quality marked by the search for an ideal after necessity has been satisfied and mere usefulness has been achieved; a quantity that makes it possible for each person to reach his maximum development. We must have quality in quantity. The challenge is for mass excellence."

The challenge is especially applicable to all of us interested in hospital psychiatry. Not only is there dire need for quantities of people to treat, care for and, hopefully, cure our patients, but there is also an equal need for excellence—for the quality of idealism, of education, of striving, of research—if we are to succeed in this Herculean task.

Professional competence of itself does not necessarily equate with excellence. As Winston Churchill has put it: "Expert knowledge, however indispensable, is no substitute for a generous and comprehending outlook upon the human story, with all its sadness, and with all its unquenchable hope."

It's all too easy for us—and I constantly remind myself and my staff of this temptation—to forget *why* we are in business. We are in business for the simple reason that some poor devil got sick. If we allow our medical students, our residents, our nurses and our aides to forget that all their efforts must be "patient-centered," it will avail us nothing to produce more and more people with university degrees, with certifications of all kinds, or with vast strings of publications to their names.

For a fallible human being such as I to have attempted to preach a sermon is indeed a dangerous, and perhaps a foolhardy undertaking. Possibly it's the result of meeting and interacting with several thousand colleagues at the Annual Meeting of the A.P.A. in Philadelphia. Now that it's all over, I have felt the need—and I'm sure everyone else has too—to spend a brief moment at the still center of the wheel and ask myself what we are all attempting to do. And we all know the answer, even if we sometimes lose sight of it. We are attempting to maintain excellence for one purpose and for one purpose only—because we are all physicians or physicians' helpers and our job is to cure the sick.

THE FAMILY DOCTOR AND THE CONVALESCENT PATIENT

BY LESLIE A. OSBORN, M.D.

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"FAMILY DOCTOR" is a long-honored description of the men who are medicine's front line troops in the battle for health. Progress on the technical front has partly obscured the personal nature of medical service: treatment of *people*. "Eye" doctor, "heart" doctor, "chest" surgeon are some descriptions which suggest that service to people has been obscured, as if physicians were mechanics servicing a biological machine. People want the family doctor back in his rightful place.

"Mental" illness itself is in many respects a poor term. Why should a family doctor be concerned with minds? They cannot be palpated, auscultated, or even checked at autopsy. All the scientific precautions which have saved us from the dark ages of medicine could come back if such intangibles were again allowed to go unvalidated. The family doctor, using the benefits of modern science in the interest of people, wants to be a physician, not a metaphysician.

Modern psychiatry has developed greatly, emerging from a vague past as has medicine generally. One would not confuse astronomy with astrology, nor chemistry with alchemy. Modern psychiatry, following Dr. Harry Stack Sullivan, is the medical application of the science of interpersonal relationships.

People interrelate in families, in groups, in society, in nations. Babies need the protection and help of human relationship to "go into orbit" as independent adults. The family is an indispensable first-stage rocket to get them off the ground. If they are damaged and incomplete before take-off, they may always be grounded as mental defectives, severe cripples, blind, deaf, cerebral palsied, epileptic; infant morbidity, before, during and soon after birth, affects ten times the number who comprise our still-too-high perinatal mortality. The family doctor has an obvious major role in getting the satellite infant ready to be launched toward the orbit of maturity's outer space.

The parents as first-stage rockets, schools as second, and the community as the third stage must all function to ensure a healthy, free, self-directing adult who can comfortably and easily keep going in the teamwork living of our modern complex society. It was simpler in more primitive times—society stayed on the ground at the subsistence and survival level, and the doctor had his hands full helping men's survival in a world of unseen microbial foes.

The family is basic to the child's start in life. If its relationships are out of line, the child's course is affected. Modern psychiatry is greatly concerned with the family and relationships as they help, are unable to help, or even hinder the growth of a human being.

The old family doctor knew little of science. The new tissue doctor knows little of people. But the new family doctor, who is the confidant and mainstay of the family, can use both tissue science and interpersonal science. He comes into close partnership with the new psychiatrist who deals sensibly with the reality of human relations problems as they can and do affect health. He too deals with the problems of the family. Both are in a position to practice medicine fully.

Monsieur Jourdain in Moliere's play was delighted to find that he had been talking prose all his life. Every physician in clinical practice is a psychiatrist, whether he knows it or not. Psychiatry is simply the *personal aspect of medical practice*. A specialist-psychiatrist deals for convenience with illnesses in which the personal, interpersonal and social problems are primary or predominant in the clinical syndrome.

A surgeon skilled in anatomy took an hour to locate a gallbladder in a thicket of adhesions. He remarked: "You'd scarcely believe disease could so disorder what started out as a normal abdomen." Physicians looking at far-advanced interpersonal lesions have had similar difficulty in linking them with the original healthy potentials of a person, distorted and disorganized by the stresses of personal and social living.

Lacking the imagination to link the grossly pathological with a sequence of stages, doctors in the past have missed the meaning of such illnesses. They have invented concepts of "demons," "bad heredity" and the like, and have lacked any practical approach to investigation, diagnosis and treatment. As the patient's illness is expressed in symptoms which the doctor must first decipher, literal treatment is like treating fevers or coughs as etiologies rather than clues.

In bygone days we copied baby-talk, confusing the baby by not using the clear, simple speech he was trying to imitate. In psychiatry, we stopped being calm, sensible and understanding. We copied the anxious, irrational expression of our patient, losing our heads when we should have kept most calm.

Medical Service With Sensitive Feeling

There is no magic to psychiatry. Its basic skills are medical service to those in need, sensitive feeling for the suffering involved, clear thinking about human problems, with the guidance by which an ataractic person calms an excited one. What physician in general practice has not noted how his coming calms patient and family alike, before anything else has happened? The public is ahead of us, expects this effect of us, and wonders why we fail to use it knowingly and skillfully.

Unfortunately, our teachers let us down in this respect. They teach us to educate our fingers to palpate, our ears to auscultate, our eyes to observe, our nose to smell. All these highly subjective senses are converted from lay sensation to educated perception. Our subjective feelings lend themselves just as much to development into skilled clinical assets.

Here we have been suppressed; be *objective* (making our subjectivity "wild"); don't get involved, and so on. But being human ourselves we are necessarily subjective about humans. A baby's cry distresses others; it is meant to, and others are so made that they have to take notice, whether they can help the baby or not. As doctors we can learn to know and control our subjectivity. Our aim should be, not objectivity, but *clear subjectivity*, validated by clinical testing over and over again. A clinical practitioner learns to rely on his judgment; he can learn to rely on his feelings.

What has all this to do with the family physician and the convalescent psychiatric patient who is leaving the hospital? Well, how did such a patient of ours feel recently when a general practitioner, examining her for a position in food service in a general hospital, turned her down flat because she had been a mental patient? It isn't hard to conjure up the feelings we would all have had in her situation.

General practitioners graduate the return to function of the rheumatic fever, the tuberculosis, the fracture, the post-operation patient. They guide a regimen which allows for increasing functional stress as functional strength returns.

They are in a key strategic position to do this for the convalescent psychiatric patient. Their psychiatric colleagues know this, and look to them to assume this natural role. Neither the understanding nor the technique is hard. Most physicians have an attitude of uneasiness about psychiatry at the bedside, yet talk mostly patient behavior in the staff room. This knowledge and skill, learned in the school of experience, can be converted to clinically-useful form despite the deficiencies, or even distortions, of learning about psychiatry in the school of medicine. There are good books to help general practitioners catch up on these deficiencies. (Modestly, I have written one myself, based on nine years of general practice and then special training and practice.)*

Anyone who has been angry with a person he likes knows what it is to have mixed feelings. Such conflict of feeling also carries mixed innervations, and simultaneous stimulation of primitive reactions, conveyed by sympathetic and parasympathetic pathways. The stress is not like that of anger with a stranger or an enemy, and the feeling is not that of requited friendship. There is an internalized strife, a sort of emotional civil war. A house divided against itself cannot stand. A baby needs love, and gets some loving care (or can't survive). Mixed with it may be some neglect or hurt, enough to give mixed stimulation of feeling, long before the brain cortex can analyze why there is trouble in the environment. Such conflict is felt as anxiety. It may begin as fear—the reaction to the outer danger—but the greater damage is that induced by the conflict within.

Some babies seem sensitive early to relatively minor stresses, and some seem able to withstand quite gross adversity. There is great danger of oversimplification. For present purposes, we are mostly concerned with the former group when considering the people who become "mentally ill." Like some plants, some children in the early stages may need hothouse conditions for proper growth, and latent problems of their parents may produce covert reactions which the doctor sees as fretfulness, crying, anorexia, etc.

William James divided people into the "tough-minded" and "tender-minded." The mentally ill person usually comes from the ranks of the latter. He internalizes his anxiety, doing a "slow burn" for years without people realizing any more than that he is "shy," "quiet," "keeps to himself," or "has a shell around him," until the inner tension brings about a disorganization or decompensation of personality. The "tough-minded," if bothered, also internalize their problems but run into outer difficulties. Perhaps "neuroses" are in between.

The shy, sensitive person often reacts paradoxically. He inhibits easily, so does not find help from criticism. He is already overloaded with self-criticism. Quiet, friendly warmth and encouragement go much further, even though his seeming coldness suggests an opposite reaction. A patient whose heart is decompensating must ignore all else and concentrate on gasping for breath to forestall impending biological disintegration. A patient whose personality is decompensating may have to ignore social realities in a desperate effort to forestall impending personality disintegration. Encouragement and personal support aid his efforts at compensation, so he calms. Criticism, or defense against the effects of an outburst if controls give way, can serve to *increase* social pressures and be a last straw to break the back of his tottering controls. Clinical experience soon shows that the former method works, leaving no need for concern about the latter in the vast majority of cases.

Quiet Friendliness and Motor Activity

The mentally ill may be thought of, in many cases, as sensory personalities who have difficulty in expression via feeling and action. We use quiet friendliness and motor activity such as occupational therapy in their treatment. We do not use extensive discussion therapy: they theorize enough already, so why carry coals to Newcastle? We help them to confident social self-expression and relationship. The neurotic patient is an effective personality—seeks to clear his thoughts and actions through help from others. The "motor personality" in trouble needs deepening of affectional and conceptual components of his life.

Helping shy people requires tact, gentleness, encouragement and something of childlikeness which we all have but tend to cover up. The mentally ill person is often one who works from within himself toward the world, and has trouble with "common sense"—tempering personal desires, etc., with practical considerations. He looks for more consistency and sense in the behavior of

* *Osborn, Leslie A., M.D., Psychiatry and Medicine; New York City, The McGraw-Hill Book Company, 1952.*

others than is usually there and needs to be helped to keep proportion and perspective.

The time element that is very considerable with helping neurotic patients is less with the mentally ill. After all, a hungry man can be given quite a lot of food; an emaciated, starving man may not take much at a time, but what he gets must be easily assimilated. The mentally ill person seeks help when he needs it from those who have won his trust. At other times, he may be impervious to it. When he seeks help, it should be given without delay and question, if possible, and advice should be given chiefly when asked, as far as the physician is concerned.

Help with the ins and outs of getting going again in society is more time-consuming, but mostly is best done by someone other than the family doctor or psychiatrist. Social workers, clergy, and helpful employers, are the patient's chief assets here. The family doctor needs to know which of these have an "understanding heart" to help, if there is no direct social work follow-up from the hospital.

A calm physician can usually feel when a patient's symptoms, discouragement or attitude suggest that the going is really more than he can stand. *Knowing the individual* is more important than cataloguing warning signs. The patient likes kindly frankness, and must be dealt with at all times in good faith. A discussion of the value of hospital readmission for awhile until he is ready to get going again should be just as natural and as easy as such a discussion about returning to the sanitarium with a patient who has a possible reactivation of tuberculosis.

Family Part of Picture

Probably the hardest part of the family doctor's role is with the family. He has to learn that "overprotection" is not a surplus of love, but a mixture of love with other, less worthy feelings which must be masked by overdoing: again, conflict in the parents, often between them. The doctor soon finds out why psychiatry is now dealing more with family than with individual treatment. The patient out of his family habitat is as hard to understand in the hospital as is a lion studied in a zoo instead of in Africa. The family doctor who becomes closely observant of family relations begins to notice just what the patient was reacting to in family life that contributed to unhealthy personality development.

Psychiatry is just emerging from two serious fallacies which prove "a little knowledge is a dangerous thing." One is parent-blaming. Our family life is part of our culture, and is in social transition as is our society itself. Parents whose babies died or developed bovine tuberculosis from milk were not deliberately hurting their children. Pasteur just hadn't arrived on the scene yet. Most of the hurts in family life are unintentional, and most reflect the past hurts of the hurter. Evaluation has to be factual but not judgmental.

The second fallacy, engendered on the basis of some interpretations of psychoanalysis, can be called emotional parthenogenesis. It was not until the 17th century that discovery

of the spermatozoon proved the father and mother both play an indispensable and equal role in reproduction. In the social reproduction of a civilized child, through affection and education, both parents are needed and equal in importance. Mothers do not bring up children, parents do. In this sense the French *les parents* wisely has no singular.

What is more natural than that the family doctor study the family? The returning psychiatric patient often re-enters the family home, and older problems are stirred up. Addition of a wise and trusted professional friend can help "catalyze" a resolution of family difficulties, to the benefit of everybody concerned.

Over-treatment has been a serious fault of ours as a profession. We scared people into fifty years of cardiac invalidism because of heart murmurs until we learned that the heart is a pump, not a musical instrument. We kept post-operative cases in bed long enough to get pulmonary embolism. We kept fractures immobilized too long to permit the weight to help redevelop the bone.

During World War I, psychiatric patients were invalided home; late treatment often meant chronicity. In World War II the psychiatric casualty was treated near the front lines—"within the sound of the guns"—and returned as soon as possible to as near as possible his usual function.

This change from "closed down during repairs" to "business as usual during repairs" is a significant one. It questions the role of *long* hospitalization in psychiatry, and emphasizes treatment on the job and at home as far as practicable. Since less has been dislocated in the patient's life, there is less to be replaced.

Family Doctor Returning

This means that the main scene of therapeutic action in psychiatry is shifting from the specialized hospital to the community. It forecasts brief hospitalization in the general hospital when needed. It tells of a sensible return from extremes of over-specialization to the family doctor. We are making a start by asking him to help with the convalescent patient. As he lets himself become involved, and loses himself in his genuine interest in people, he will assume an increasingly important role.

This is as it should be. Such a shift has taken place in tuberculosis from the sanitarium to the office and mobile X-ray unit, and the sanitariums are emptying. Return of the family doctor, and early help with family problems likewise constitute our best hope for emptying our psychiatric hospitals.

Military men say you can't win the next war with the weapons of the last. Aseptic surgery, preventive innoculations, roentgenography, scientific nutrition and antibiotics have won past wars against long dread illnesses. The war against mental illness requires new methods in keeping up with the kind of problems presented. Drugs are helpful adjuncts properly used, but the prime resource for illnesses engendered in the stresses of human relationship is helpful human relationship. Where better to look for that than to the family doctor?

Patients Go Camping in Indiana...

By **ORA R. ACKERMAN, M.Ed.,** *Coordinator of Activity Therapies,*
SPIRO B. MITSOS, Ph.D., *Chief Psychologist,*
A. MARGARET SEYMOUR, O.T.R., *Director of Occupational Therapy,*
Evansville State Hospital, Indiana

IN SEPTEMBER OF 1958 two groups of patients from the Evansville State Hospital became the first participants in a camping experience which promises to become a regular part of the hospital's activities program.

This was a joint venture, with the hospital providing the staff, food, linens and general supplies, and the Indiana Association for Mental Health furnishing funds for the rental of the camp as well as for incidental expenses, including camp clothing and pin money for the patients.

The camp site is located at Lincoln State Park some 40 miles distant from the hospital. Facilities include a large dining-recreation building, groups of sleeping cabins, an infirmary, a central shower house, staff cabins and an office. Sleeping cabins are arranged in four units with each unit having three cabins and each cabin accommodating twelve to fourteen campers. Each unit has its own toilet facilities and a separate staff cabin. However, in our case none of the staff cabins were used as the entire staff shared sleeping quarters with the campers.

Sixteen staff members from the hospital were involved in the camp project. The coordinator of activity therapies was camp director, with the director of occupational therapy serving as assistant camp director. The remainder of the staff consisted of nine members of the activity therapy department, two registered nurses, two attendants and the camp chef, an employee of the dietary department.

Patients selected to attend the camp were carefully screened and selected by different criteria each week. The first week's campers were a group of younger convalescing acute patients. Campers for the second week were selected from the older chronic patients, with special emphasis on two points: (1) they must be working patients deserving of a vacation, and (2) they must be patients having few or no visits from relatives or friends.

Because it was intended that the camp would be a place of few restrictions and ample freedom, there were no locked doors anywhere. Instead, an imaginary boundary was set up and within this area campers were free to go where they pleased when they were not in an organized activity. To our knowledge no camper abused this privilege.

Besides caring for his own personal hygiene, each camper had several regular assignments and duties to perform each day. He was responsible for making his bed and helping keep his cabin clean. On a scheduled basis members of the various cabins were responsible to all other campers for preparation of meals, serving meals, or cleaning up. In all of these aspects of the camp activities, staff and campers worked together.

The recreation and craft programs ran concurrently

and incorporated different activities each day. The composition of the groups themselves also changed daily. This was easily accomplished since none of the specific projects were of such magnitude as to require more than one of the craft periods.

Campers Participate Freely

In both recreation and craft activities, in fact in the entire camping enterprise, the most encouraging factor was the camper participation. At no point in the program was anybody forced to participate, but nearly everyone took part in the various programs. Emphasis was placed on having each camper experience as great a variety of activities as possible.

Probably the best indication of the success of the initial camping project is the fact that no consideration has been given to not repeating it. Plans have been under way since March for this year's program, which is expected to differ from last year's only in regard to personal freedom. The consensus is that last year's schedule was a little too "tight," and that a relaxing of the planned activities will enhance the therapeutic experience.

. . . And in Texas

By **BERT KRUGER SMITH**
The Hogg Foundation for Mental Health,
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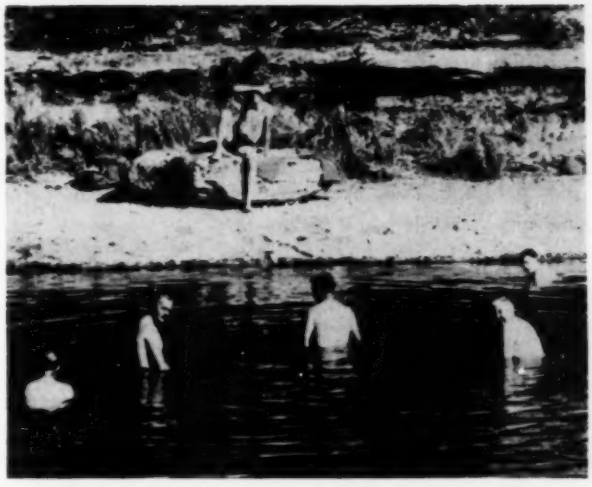
MORE THAN 500 PATIENTS have already been privileged to share in the Texas state hospital camping program which began in 1956. Now an annual event under the sponsorship of the Hospital Board, this has become an exciting and promising new development in the state's rehabilitation programs.

The camp site was made available without charge to the state hospital system, as it is to other worthwhile endeavors, by the H. E. Butt Foundation. Mrs. Eleanor Bird, rehabilitation therapist for the Kerrville State Home, was named director of the camp. Her many years of camping experience and her unquenchable belief in the camping project have been largely responsible for its successful continuation.

The selection of patients and of personnel was quickly recognized as the most vital ingredient in conducting the program. Persons responsible for the camp regard as essential the careful screening of patients to select those ready to test their skills in living—skills which can best be tried in a protected situation away from the hospitals. In no sense is the camp regarded as a "vacation site" for long-term patients nor as a rest for those who have worked faithfully in the hospitals. Rather, it is a proving ground for living.

Authorities recognize that a patient cannot test himself fully inside the protective arms of the hospital, nor



Top: Texas hospital patients stand on the patio of the main lodge and look out at the hills. Bottom: Patients, many of whom have not swum in years, enjoy the pleasures of the Frio River.

is he always certain enough of himself to move directly from hospital to the strains of home and community living. But at camp, which might be considered a stepping stone toward home, the patient can test himself in true democratic living, while at the same time having the protection provided by trained personnel and the camp setting. For the first two years of the program thirty patients from each of the six Texas hospitals, two hospital groups at a time, came for a one-week stay. During the third year this was increased to ten days.

A permanent camp staff has been made available, with the hospitals providing a doctor, cabin counselors, a safety counselor, a rehabilitation therapist and food service personnel. Camp personnel attend a two-day workshop before the arrival of the patients in order that they can learn about camp facilities and can discuss and evaluate techniques of group work in a camp setting.

What do these days at camp mean to the patients themselves?

Reluctance is often their first reaction, unwillingness to go from the protection of the hospital, hesitation at leaving the nurse or attendant who has become a sort of mother figure, reluctance to make decisions again. The trip itself in a big, modern bus is often a frightening experience for patients who have been on hospital grounds for many years.

Sometimes on the bus trip they sit rigid, turning their heads from the unfamiliar scenery, fearful of noisy streets and careening cars. They fight what they do not know. Gradually the movement of the bus, the sight of trees and tangled wild flowers, the spotted cows munching grass begin to bring peace into their bodies.

Still many of the fears remain. As the bus turns into the sloping road to the camp, many of the patients regain their uncertainties at the sight of the narrow road and sharp curves. At this moment the camping program begins. Mrs. Bird, her blue eyes alive with laughter, steps into the bus and rides the remainder of the way with the group, enthusiastically telling stories of exploits along the old wagon trail on which they are traveling, laughing with delight as the bus lumbers into the river bottom, its huge tires splashing water over the rocks.

From that moment on the group becomes campers, not patients. They are never referred to as patients as long as they remain in camp.

Finally they step stiffly from the bus and look around, viewing the tree-clothed hills, the cabins and main lodge of rustic stone, the scrub oaks bathing their feet in the Frio River.

They hear the underbreath of wind humming through the canyon. They see the river licking gently at the rocky banks; they feel the earth, still warm with remembrance of summer. They smell the pungent smoke of wood, and they taste the crusty skin of potatoes roasted over an open fire. Thus are all five senses newly brought to remembrance of past wonder and latent beauty.

The setting itself is therapeutic. A middle-aged man whose twenty years on the farm still show in the sun-squint lines around his eyes crumbles the earth between his hands and feels once again its promise. A young girl who has been inside the hospital for five years sees the water and is washed with remembrance of cleanliness and joy. And an older woman sits quietly on the sun-spotted terrace and warms herself with the peace and stillness of the moment.

Personnel Also Enjoy Camping

This almost magical transformation comes not only to the patients, but to the personnel. In this non-institutional setting, without their uniforms, away from hospital pressures, they also become campers. Now they can give leadership to patient-campers only when necessary and can work with them in a person-to-person role.

Patient-campers are shown to their cabins, each one housing fifteen persons from the two hospitals plus a camp counselor. They unpack their boxes carefully, looking around the big room, delighting in the corner fireplace, smelling the air of freedom. At dinner the first night the camp director explains the principles of camping, and the democratic process begins. Council women or councilmen are elected from each cabin, and they begin to sit in on decision-making about future activities. There are no rigid assignments concerning programming but rather a truly democratic choice of group activities and duties, the latter consisting of cabin cleaning and helping with the kitchen chores.

No doors are locked—no two days are the same: Ten simple words which spell a change in life, in outlook, and in feeling for people who have listened for hundreds of nights to the sound of keys turning in locks, who have awakened in the morning to the knowledge of a one-colored life filled with routine.

To some the activities—fishing, hiking, swimming, games, singing—provide the greatest experience. To others the blessed joy of sitting alone under a tree and watching the simple grace of a spotted fawn, the proud tramping of a wild turkey, the setting sun spilling its red-gold beauty on the canyon brings release of spirit.

The buddy system is used at all times, and no accidents have occurred at camp. Each activity is a miracle to the campers and a tribute to the personnel. The mere act of providing swimming in the Frio River takes both ingenuity and vigilance. A water-front counselor is on hand at all times, and dozens of campers who have not known the joy of swimming for years are buoyed up by both the water and a sense of well-being.

An older man who said, "I never thought I'd fish again," takes the fishing poles in his thin, veined hands and is happy as he has not been for years. Hiking through the hills, participating in sing-songs and fish-fries bring to these campers a renewed sense of life's goodness and their own worth.

Herman might serve as an example of what the camping program can do for patients. In the hospital and when he first came to camp, he was mute and uncooperative. As he started fishing, he also began talking with the other campers. At the end of his week at camp, he was voted the "Camper Who Had Improved the Most." As he left camp, he remarked to the director, "Say, if I can get along with people like this, I could do it back home." Before long Herman was discharged from the hospital and is now holding a job in his community.

Or take Linda, a former school teacher who had been in the hospital for eleven years, much of the time combative and confined to a back ward. Tranquilizing drugs had helped her, though she arrived at camp still fearful. The first night, sitting around the camp fire, she sang a solo. From then on her progress was remarkable. "I know I can get along with people," she said. "I know I can plan." Within a month she was discharged from the hospital and had made plans to return to college for some refresher courses.

Dr. Cyril J. Ruilmann, medical director for the Texas state hospitals, has said of the camping program: "I have great faith in the ability of this program to provide for many patients a unique kind of interpersonal relationship which plays a real part in preparing the patient to return to the community. I would like to see the program expanded to the degree that every patient who could profit from it could be allowed all the time he or she needed in the camp experience."

USES OF THE PAST

IX. American Quakers and Architecture

THE SOCIETY OF FRIENDS in Philadelphia had discussed the need for a hospital for the mentally ill as early as 1709, but it was not until 1813 that they began to solicit funds for the construction of such an institution. One member of the committee, Thomas Scattergood, had visited the York Retreat in England and he and other committee members were deeply influenced by the concepts of their English colleagues. When Samuel Tuke wrote a report of the experiences of the York Retreat in 1813, the American Quakers published an American edition which they circulated with their requests for funds.

When the Friends' Asylum was built, it was architecturally simple, devoid of extraneous ornamentation, and followed the general design of the York Retreat, with a central building and two wings. The linear arrangement of the building, which faced northeast, was devised to allow for ample fresh air and light. The central building was a 60-foot square, and consisted of a basement, three floors, and an attic, with four large rooms on each floor. The basement was devoted to the kitchen and a storeroom, as well as rooms for ironing and baking. Crossing corridors divided the main floor; the one running from front to back established passage through the building and contained the main staircase, while the transverse corridor led to the patients' areas. The two large front rooms were originally the superintendent's office and parlor, with the two rear rooms serving as patient dayrooms, as did corresponding rooms on the second floor. The superintendent's family occupied the front area of the second floor. The third floor contained the apothecary shop and a sitting room for convalescent female patients.

The two-story wings, each 100 by 24 feet with attic and basement areas, were set some 18 feet back from the front of the center building. Each wing contained 20 patient rooms of 100 square feet each, on the southwest side of the building and opening onto a well-lit corridor 10 feet wide. These corridors allowed for exercise on inclement days. The York Retreat had rooms facing each other, but the Friends' Asylum eliminated opposing rooms, thereby increasing the quiet and the available light and air.

Male patients were housed in the east wing and women in the west, and a further classification was attempted by degree of illness. Convalescent female patients were housed on the third floor of the center building; nearly-well, harmless, and quiet patients of each sex occupied the upper stories of their respective wings. The lower story was reserved for the intermediate, the violent, and the incurable. At times patients who became too vociferous were lodged in the attic of the center building.

In 1827-1828 two new buildings, intended to house the violent patients, were appended to the ends of the wings. The front walls of these buildings were attached to the front walls of the wings, but otherwise the buildings were separated by a distance of five feet. On the ground floor this space became a corridor to the yard, while on the second and third floors it held the staircase. The common wall was made of extra-heavy material to prevent transmission of sound, and the patients' rooms were located on the extreme end, with no view of the main part of the building.

Every attempt was made to avoid the appearance of confinement. Windows in almost every room were, in contrast to those at the Retreat, accessible to the patients. The windows were made with a fixed cast-iron sash, with the lower portion glazed and the upper, open portion protected by an external wooden and glass sash which could be raised and lowered at will. Escape was difficult, but the appearance was quite ordinary and there was adequate fresh air and light. In the center of each door was a seven-inch square opening which allowed for unobtrusive observation of the patient and passage of food if a patient was in seclusion.

Adequate heating in the early hospitals was always a problem. Every attempt was made to build as fireproof a building as possible, using stone and slate for the main construction and brick and mortar wherever added protection was needed. The center building was heated largely by stoves and grates, which had guards attached for the safety of the patients. Ovens located under the arches in the basement heated the wings by means of hot air conveyed into the corridors in two places and piped separately into several of the rooms. The lodges had their own furnaces in the cellars. Cooking was done in the center building basement, and meals were generally served in the dayrooms. The water supply was pumped from a nearby spring and stored in reservoirs under the roof of each wing. Toilet facilities, however, were still external, not only to the main building, but also to the enclosed court area.

The patients' airing courts, each a little over a half-acre, were located on the south side, behind each wing. These courts were planted with grass and in later years had summerhouses and animals. They were enclosed by wooden fences some ten feet high. An eight-inch board, approximately eight feet long, was hinged to the top of the fence in such a manner that when grasped it would fall toward the inside of the court, thereby dropping a would-be escapee. The board was also attached to a wire connected to bells which would ring at any attempted escape. In 1833 the wooden walls were replaced by stone ones of similar height. The courts were later subdivided into a separate third for the idiotic and filthy patients.

An attractive flower garden occupied the space between the courts. Since the rear entrance to the main building consisted of a vestibule with seats and venetian blinds, convalescent patients were able to enjoy the beauty of the view. At the end of the flower garden there was a cedar hedge, beyond which was located the kitchen garden. The two gardens occupied a total of approximately two acres. A winding path led to the woods in back of the asylum, where there was a tranquil summerhouse that patients frequently visited.

ERIC T. CARLSON, M.D.

she needed in the camp experience."

A Psychiatric Unit in a Teaching Hospital

By F. E. COBURN, M.D.

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When the University Hospital was planned in 1946, a 40-bed psychiatric unit was included to provide clinical material for the teaching of medical students. The building opened in 1955. The psychiatric ward was designed like the other wards except for four single (or isolation) rooms at the end of one corridor. The unit consists of two wings at right angles to each other with the nursing station at the wing juncture.

In one wing the beds are four to a ward with six-foot partitions installed to create two-bed areas. There is a washroom between each two wards. The other wing is made up entirely of standard private rooms. There are no special screens, no bars. Furnishings are comparable to those found in the best private hospitals.

Unit Entrance is Unlocked Glass Door

The unit is located on the fifth floor of the hospital and opens directly onto the main elevator rotunda. Its outside door is glass and the fact that it has never been closed or locked is an indication of the general policy of the unit.

Occupying the rest of the floor is the ward for the department of rehabilitation medicine, the recreation area and occupational therapy shops and the psychiatric offices. Patients from the psychiatric wing share the cafeteria with patients from rehabilitation medicine.

With such an open door policy, one might expect a very careful selection of cases, with admissions limited to neurotics or the quiet depressives. Such, however, is not the case. Admission has never been refused because of the severity of a patient's symptoms. This unit receives any psychiatric emergencies arising in a city of 80,000 or in the 550-bed general hospital; it also admits some teaching patients from outside the city. With the exception of a very small number of patients who are admitted for less than 48 hours pending arrival of transportation from the provincial hospital, all admissions are kept on the ward and treated. No patient is ever transferred to the provincial hospital as too disturbed to be kept.

The diagnoses of patients admitted in 1958 were as follows:

Schizophrenic disorders	95
Manic-depressive reaction	44
Involutional melancholia	39
Paranoia	6
Senile psychosis	11
Presenile psychosis	1
Psychosis with cerebral arteriosclerosis	5
Alcoholic psychosis	2
Psychoses of other demonstrable etiology	6
Psychoses—other	16
Psychoneurotic disorders—all types	130
Disorders of character, behavior and intelligence	120
Others	20

(Total of diagnoses is more than total of patients as some patients are given two diagnoses.)

With such an unselected population, including psychotics, it has surprised not only the hospital administration but even some of the psychiatrists that so much freedom and non-restraint are possible. We are just not bothered by the type of disturbance which some of us had experienced in a more repressive setting. Patients on admission are sometimes disturbed and noisy but usually, within 12 hours, they stop being troublesome. The tranquilizing drugs may play some role here, but a much smaller part than had been anticipated. One major factor seems to be the large staff-patient ratio. Responsibility for the 38 patients is divided among six

staff psychiatrists, with six residents providing direct patient care. Other staff consists of:

Day Shift	5	R. N.'s
	1- 2	ward aides
	1- 2	orderlies
	10-14	student nurses (part time in classes)
Evening Shift	2	R. N.'s
	1	ward aide
	1	orderly
	2	student nurses
Night Shift	1	R. N.
	1	ward aide
	1	orderly
	1	student nurse

For two years now the unit at the University Hospital in Saskatoon has had a general practitioner on its staff. He admits patients to beds assigned to him and treats them himself with the backing and consultation of the psychiatric staff. This arrangement has proved highly successful and shown that some family doctors, at least, can with help provide good psychiatric care.

The most common treatments are short-term, dynamically-oriented psychotherapy, electrotherapy and manipulation of the patient's environment. There is a vigorous program of occupational therapy, which is divided into five phases. For all patients who are physically able, the occupational therapists conduct setting-up exercises each morning. For the rest of the day, those patients who can leave the ward spend one-half day in socialization activities—games, etc., and the other half in the traditional occupational therapy activities. For those patients who are aged, infirm or confused, there is occupational therapy in the dayroom, conducted by the nursing staff under the direction and supervision of the occupational therapists.

There is a social hour each evening. This is patient-planned and directed and is under the general guidance of the occupational therapy department. The hospital library provides adequate reading material for the patients, and the dayroom is equipped with radio, television, chess, checkers, crossword puzzles, playing cards, etc.

The nursing staff conducts an activity program aimed at maintaining or improving the patients' level of socialization and providing a maximum opportunity for interpersonal reaction. Patients are encouraged to spend time out of their rooms unless they are quite ill or severely upset.

It is the usual policy to place a patient under constant observation when he is severely disturbed; this simply means that a nurse or attendant is with him at all times. Such close contact with an accepting and supporting person is remarkably effective in relieving many psychotic symptoms.

There has been one important deviation from the original plan for this unit. The four single rooms for the seclusion of severely disturbed patients have never been needed for this purpose. Instead, these rooms now serve as a quiet area for those patients who are most responsible and who require the least supervision.

The Saskatchewan Plan

The Provincial Psychiatric Services Branch has developed the Saskatchewan Plan for treatment of the mentally ill. This provides for the building of small units closely connected with general hospitals and so distributed that patients need go only a short distance from their homes. These units will provide high level care, keeping the patient close to his family and community and maintaining his connection with his family physician. It is also hoped that many psychiatric patients may be treated in these hospitals by their own physicians under psychiatric direction.

It is intended that the community mental hospital will be the basis for a comprehensive psychiatric service throughout the region in which it is situated. In addition to traveling clinics and pre-admission home visiting by psychiatric personnel, these units will provide such variations of service as day-hospital care, night-hospital care, weekend care, and hostel accommodation for patients who are being rehabilitated into jobs. By providing treatment with minimum disruption of the patient's life and work, it is believed that rehabilitation can become much less difficult.

In Saskatchewan virtually all hospitalization is covered by the Saskatchewan Hospital Services Plan which is a system of compulsory hospital insurance. Because of this, all patients have the status of private patients; there is no indigent class. Patients are assigned to their accommodations on the basis of psychiatric condition rather than financial ability. This private-patient status has caused virtually no problems. When properly approached the patients are pleased to participate in teaching exercises, and even the most psychotic patient rarely refuses to be interviewed in front of a class or by individual students.

The per diem cost in this general hospital is $21.50. Although costs are not broken down on the basis of departments, it would appear that the costs on the psychiatric ward are approximately the same as in the other parts of the hospital. There is a slightly larger nursing staff but the extra cost here is reduced by smaller use of laboratory and X-ray facilities.

The average length of stay in the psychiatric unit is 32 days. Of those patients who are not immediately transferred, about four per cent are eventually transferred to the provincial hospital, the rest being returned to the community. Another three per cent eventually go to provincial hospitals after their return home.

Experience on this ward has shown the feasibility of treating all types of mental disturbance on an open ward in a general hospital. It has been done with good results to the patients and without disturbance to the rest of the hospital. The costs are those of general hospital care and it would appear that these brief, high-cost treatment periods may have allowed the patient to avoid much longer periods at a lower per diem in the large mental hospitals, either now or in the future.

A.P.A. Section on Mental Hospitals 115th Annual Meeting, 1959

Under the chairmanship of Alfred H. Stanton, M.D., four papers on various aspects of the public mental hospital were presented in the Section on Mental Hospitals at the 1959 Annual Meeting of the A.P.A. Alfred P. Bay, M.D., succeeds Dr. Stanton as chairman of this section for 1960. The authors' own summaries of their papers are presented below. The papers were discussed by James S. Tyhurst, M.D., of Vancouver, B.C., and Harry C. Solomon, M.D., Boston, Mass., Past President of the A.P.A.

THE STATE MENTAL HOSPITAL IN TRANSITION

In the last decade state mental hospitals have demonstrated their growth and vitality through significant gains in accepting and discharging responsibility for *treatment* of the mentally ill by: (a) increase in and upgrading of professional and ancillary personnel; (b) multiplicity of treatment methods; (c) attitude to and effort in research; (d) attitude to and effort in residency and inservice training; (e) use of architecture as treatment; (f) acceptance by legislatures and official agencies of their responsibility to the mentally ill and the emotionally disturbed; (g) extension of hospital towards the community, e.g. through mental health clinics, and of community towards the hospital, e.g. through volunteer programs; (h) persuading medical schools of their responsibility to mental hospitals and demonstration of the research and teaching potentials in their enormous laboratories of human psychopathology; (i) provision of directors of research at the highest administrative level and by increasing interest of grant-giving organizations and foundations.

Program improvements include the establishment of day- and night-hospitals and the extension of the state hospital into the community through the increasing establishment of psychiatric units and clinics in general hopitals. Just as the use of chemotherapy spread quickly from the state hospitals to the profession in general, methods yet to be found will repeat this history.

Growth and improvement in administrative practices are permitting a more productive use of the psychiatrist's training and of his time, as evidenced by expanding use of individual and group therapy and by teaching assignments for the upgrading of non-medical personnel. Increasingly, whole organizations are becoming patient oriented and therapeutically minded, e.g. the therapeutic community, milieu therapy. Many "back wards" have moved to the front and countless locked doors have opened. Hospitals are acquiring the knowledge that the healing process in state hospitals is inherent in the total organization, from the superintendent to the psychiatric technician, and that neither can do his best for the patient without the integrated intervention of the other.

These evident examples of growth bespeak the vigor of the state mental hospital and attest to the probability that increasing numbers of trained brains will be eager to join in the transition of state hospitals from grim human depositories to centers for recovery and for community leadership in the preservation of mental health.

Difficulties of development and impatience with the tempo of growth have never been solved by abdication of leadership. The medical profession is charged with the prime responsibility for the preservation of life and health, and no matter how onerous this burden may be, it cannot delegate the task to others and remain true to its commitment.

FRANK F. TALLMAN, M.D., *Professor of Psychiatry, and Head, Division of Preventive and Community Psychiatry, UCLA Medical Center, Los Angeles, California*

THE MENTAL HOSPITAL: CORNERSTONE FOR COMMUNITY PSYCHIATRIC SERVICES

During the past several years there has been a change in concept of the function of the mental hospital. In Great Britain and other countries, community mental health services have grown up in association with the public mental hospital. In many areas abroad, the mental hospital has been successfully integrated into a total mental health service. In the United States, this concept is beginning to be accepted. The size and location of some of our mental hospitals will limit participation in an integrated community program. Developments in the field of communication and transportation may make it possible for even remotely located hospitals to extend their services to the community level.

Some of the leaders in American psychiatry have condemned the conventional mental hospital to oblivion. Such thinking does not take into account the valuable contribution that the hospital can and will make to improvement in care of mental patients. The widespread acceptance of the Open Door Program and the recent development of research units in our mental hospitals are but two examples of the changing scene.

With our present therapeutic tools only a small per cent of persons developing mental illnesses can be successfully treated at the community level outside of a mental hospital. In spite of therapeutic advances, the number of chronically ill patients requiring hospitalization is very large. It has been suggested by some of our leaders that the chronic mental patient should be abandoned to some discipline other than psychiatry. To those of us charged with the care of the chronic mental patient, this suggestion approaches therapeutic

nihilism. If effective treatment methods are to be developed in psychiatry, we must continue to work clinically with the unrecovered patient. The development of intensive treatment programs directed toward the unrecovered patient in the mental hospital is another indication of the continuing necessity for strengthening of the mental hospital and its relationship to community psychiatry.

FRANCIS J. O'NEILL, M.D., *Senior Director, Central Islip State Hospital, New York*

CONSIDERATIONS IN DETERMINING A MODEL FOR THE MENTAL HOSPITAL

A lively controversy is now in progress over the appropriate model of an inpatient facility for mental patients. Advocates of small hospitals take issue with those of large hospitals; partisans of psychiatric sections of general hospitals tend to be at odds with those who support the use of state mental hospitals. This controversy reflects a ferment in the field of psychiatric care. From this we might infer that attempts are being made to reconceptualize the assumptions and frames of reference upon which practitioners are proceeding. We hope, in this paper, to clarify the nature of the controversy by presenting some issues that have to be confronted and some central questions that have to be asked and answered before a solution can be found.

The first of these issues concerns the universe of discourse within which the controversy proceeds. When one or another model is advocated, is the referent the desirable or the possible? Some subsidiary questions follow: What are thought to be the conditions limiting the possible? What are the bases for preferring the desirable? What is seen as the gap between the desirable and possible? What time dimension is being taken into account?

The second issue involves the purposes and goals of an inpatient facility. The questions that need to be asked are: What are its purposes? Which one(s) predominates? What equilibrium of purposes is achieved? Whose purposes and whose interests are being served? What is the rationale for pursuing one or another of these purposes?

Related to purposes and goals is the issue of the means to be used in achieving them. What kind of social structure is advocated as a vehicle?

The fourth issue is related to the assumptions being made about mental illness and its treatment when one or another model is advocated. What do patients need? What processes will provide effective help? Will more than one model of a treatment facility be needed? If so, what models are appropriate for what kind of patients?

Finally, what values, other than treatment values, are implied in the models suggested? What are the bases of these values about how patients ought to live?

Up to the present, the controversy has been carried on at the level of assertions, based on what seem to be differences of opinion. If the protagonists explore the above issues carefully, perhaps the discussion can then be directed to the fundamental and more covert problems that underlie these differences of opinion.

MORRIS S. SCHWARTZ, Ph.D., *Director, and* CHARLOTTE GREEN SCHWARTZ, M.A., *Associate Director, Task Force on Patterns of Patient Care, Joint Commission on Mental Illness and Health, Cambridge, Massachusetts*

A PROPOSAL FOR A COMMUNITY-BASED HOSPITAL AS A BRANCH OF A STATE HOSPITAL

If one believes, as I do, that chronicity in mental illness is more a result of the social structure in the hospitals which we have set up to take care of the mentally ill than of the illness itself, then it must follow that we must seek to modify the setting and mode of care and treatment. Our typical public mental hospitals are over-large, their social standards are artificial and total, they are isolated, they perpetuate ostracism of patients and personnel.

I think it is necessary to re-create the mental hospital setting in the community, returning the care and treatment of the mentally ill to the main stream of medicine. A small acute intensive treatment hospital based in an urban community from which a considerable number of patients come, supported by outpatient services for pre- and post-hospital care, making use of all the community facilities and resources would mean probably that hospitalization for mental illness would become an

episode in the course of the total care and treatment of the illness rather than an end in itself.

A hospital of 75-100 beds with a community base and orientation would probably take care of the same caseload as a 300-bed building on the grounds of a distant and isolated institution. The community-based hospital would use all the resources of the community. In addition, it would make it possible for relatives and friends to visit for brief periods at frequent intervals instead of for long periods occasionally and they would not have to take a day off from work and a long bus trip. It would make it possible for family physicians to continue to follow patients while they are hospitalized for mental illness as they do now with physical illness. It would make it possible for clergymen to continue to see members of their congregations.

However, all of the states are committed already to the care of many thousands of their citizens in existing hospitals, and the level of this care must not be permitted to deteriorate. It is proposed, therefore, that the community-based hospital mentioned above should be established as a "branch" of the parent state hospital. It is further proposed that it be in one of the urban communities served by the parent hospital and that it offer its full spectrum of psychiatric services to the patients deriving from that city or urban center, but that the parent hospital continue to operate acute-intensive treatment services for persons from those portions of the state outside the particular urban center where the branch hospital is located. This would mean, it appears to me, that the level of treatment at the acute phase would continue to be high in the parent hospital as well as in the branch and that there might be, for training and other purposes as well as for research, a free interchange of personnel between the two institutions, all under the supervision of the same responsible superintendent. It would further mean that the transfer of patients from one institution to the other or back again would be facilitated.

This seems to be an inevitable and natural development of modern psychiatric treatment theory. The existence of a building over 70 years old, obsolete, dilapidated and needing to be replaced in Connecticut, has given the opportunity to try to put this concept into early practice. A bill has been introduced in the Legislature to authorize that the dilapidated and obsolete building, housing 300 patients, be torn down and replaced, not on the grounds of the parent institution, but by a "branch hospital" of 75-100 beds with necessary outpatient, day-care and night-care services physically located in one of the urban communities served by the parent hospital. It is further hoped that such a branch hospital can be built contiguous to a general hospital so that it will not be necessary in constructing the branch hospital to build X-ray departments, laboratories and operating rooms, but rather that these services and medical and surgical services may be purchased from the nearby general hospital without duplication of services in the branch.

WILFRED BLOOMBERG, M.D., *Commissioner of Mental Health, Connecticut State Department of Mental Health, Hartford.*

For The Bedridden and Incontinent

DIAPARENE OINTMENT— Therapeutically effective for decubitus ulcers, and controls offensive odor usually encountered in incontinents.[1,3] When applied to skin after each change of bed linen and after each bath, promotes rapid healing of ammonia dermatitis.[2]

DIAPARENE PERI-ANAL CREME— Healed or improved all cases of decubitus ulcers under observation.[2,3] An efficient and safe agent in the prevention and treatment of peri-anal dermatitis.[4]

DIAPARENE DUSTING POWDER— Dusted into bed linens, works as adjuvant therapy with DIAPARENE RINSE for decubitus ulcers, with a marked decrease in the usual offensive odors.[1,3] Used with DIAPARENE OINTMENT, cleared up or improved all cases of urinary dermatitis.[2]

DIAPARENE SURGICAL SOLUTION— DIAPARENE impregnated dressings, diapers, or towels are effective prophylactically in urinary excoriation.[5,6] Use of this solution results in evident reduction in ward odors.[1,6]

HOMEMAKERS PRODUCTS DIVISION • George A. Breon & Company, 1450 Broadway, New York 18, N. Y.

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THE PATIENT SPEAKS: INTER-PATIENT RELATIONS

By ALVIN R. HOWARD, Ph.D.
Chief, Clinical Psychology Service
Veterans Administration Hospital,
Sheridan, Wyoming

THE ROLE of the mental hospital patient on the treatment team, while not a new issue, certainly remains an intriguing one. In our daily activities with patients, we reflect substantial agreement with the principle that more fruitful results obtain with the patient who aids in his treatment than with the individual who resists our advances. In the December 1958 issue of MENTAL HOSPITALS (p. 5), Ortega asserted that "the best adjunctive therapists, under adequate supervision, are the patients themselves."

The views of a former mental hospital patient concerning patient-patient relationships, here excerpted, were offered during a recorded interview when he revisited the hospital eight years after his discharge. (He is the oldest of four siblings, migrated to the United States from South America at the age of eight, completed high school, spent two years in the military service, married a woman three years his senior, and has four children. He owns his home and is director of personnel for a small manufacturing concern.)

Earlier in the day the former patient had mentioned the "Big Brother Movement" and said he thought it advisable to attempt to reach a patient through another patient. This was later discussed during the recorded interview with the author and Dr. Henry Luidens, a psychiatrist. The former patient is identified as Daniels. The discussion focused first on the suspiciousness that surrounds personnel-patient relations:

Howard: And, as I recall, you thought that [reaching a patient through another patient] would be better than any attempt that any of us might make.

Daniels: It would. Because, you see, any attempt that you or any staff member could make toward the patient will be construed with suspicion—as to what's your motivation in doing it.

Luidens: Yes.

Daniels: You see there's something about it—they [patients] used to wear the red jackets here!

Luidens: Yes, right after the war.

Daniels: Now that, in a sense, is good because the patient could identify the patients from the staff—(laughter)—and that way when a patient saw another red-jacketed fellow on the ward coming up and wanting to do something for him, he didn't mind it so much. Well, they're comrades in misery.

Luidens: Mm hmm.

Daniels: But see, in walks a young man with nice tie and suit, "Come on, why don't you come outside and play?"—or a white-jacketed man who might also be identified as the man who takes him to shock, or the man that had to subdue him once. He's not too happy about it.

The ex-patient then contrasts the tenor of personnel-patient relations with the tenor of relations solely involving patients.

Daniels: A fellow patient, of course, is another story. Uh, if a fellow patient came up to me and wanted to console me, well that's a different story. He knows how I feel. You don't know how I feel. You persecute me. You call me a homosexual. You won't give me a pass to go with my wife.

Luidens: Mm hmm

Daniels: You won't let me out to get a drink.

Luidens: Mm hmm

Daniels: But this guy, he's in here with me. He gets deprived of the same privileges I do.

Finally, he offers a concrete proposal for implementing his views.

Daniels: Can I make a little suggestion?

Howard: Sure.

Daniels: The "buddy" system. Move the guy right on into the ward. Have them bunk together. Feed them at the same table together—side by side. Cultivate these close associations. Again I go back to the animals. In India, they do it with wild elephants. They take a tame elephant and a wild elephant—and it works. I don't see that there's much differentiation between a human being and an animal, especially when inhibitions have left them—right and wrong have left them.

Luidens: You've got a helluva strong point there. All I know about this "buddy" movement—in the earlier days they'd cultivate a strong patient to control the rest of them. That's the last that I know about actual practice. Ward personnel sometimes cultivate a man with a big physique to help them control the other people.

Daniels: I mean "buddy-buddy." I mean—this way—if one man sits alone, his buddy will go and sit with him, wherever possible. And eventually, by association he'll know this guy's always with him, so next thing you know he might try talking to him. Once he starts talking, there's no limit to who else he might talk to.

Luidens: Mm hmm

Daniels: Eventually he might talk to you.

Luidens: Mm hmm

Daniels: And uh, that would be big—

Luidens: Especially if he sees his buddy do it.

Daniels: Yeah.

Luidens: He might pick up courage, huh?

Daniels: If the buddy treats this guy with friendship, well then, he might try treating him with friendship.

Luidens: Yeah, that's worth a try.

How many persons will agree that the proposal is "worth a try" is, as yet, undetermined. The perceptions of former patients are rarely obtained in any standardized fashion and even less rarely are they presented in print so as to provide a feedback for hospital personnel. We need to know more about the reaction of patients to Ortega's view and the excerpts presented here are designed to aid in this regard.

The Role of Ancillary Personnel In the Total Treatment of Psychiatric Patients

By J. P. KAHN, M.D.
Acting Associate Professor of Psychiatry
Stanford University School of Medicine
San Francisco, California

TO TREAT THE MENTALLY DISTURBED requires special skill, knowledge, and understanding on the part of each person who deals with them. Emotional ties and reactions similar to those that a mentally ill patient has to his physician also exist between the patient and the ancillary personnel. This staff does not need the same degree of comprehension of the patients' psychopathology as does the psychiatrist, but they must feel compassion and respect. They must be psychiatrically oriented enough to realize that each patient's present relationships are patterned by his earlier experiences in infancy and childhood.

The activities presented by skilled personnel can play an important role in the recovery of the mentally disturbed if such workers are reasonably well-adjusted, understand their own needs and the ways in which these needs are fulfilled, and, above all, realize that meaningful interpersonal relationships are the basis and goal of their work with patients. Activity therapists must have enough satisfaction and security in their own non-professional life to forego the temptation to use patients to fulfill these needs. They must be sufficiently secure to deal, in a constructive way, with the patients' hostility, ridicule, advances, regressed behavior, and altered and decreased capacity for object-relationships without becoming uncomfortable or adopting a punitive attitude. Such personnel, by virtue of their particular work with patients, their understanding and accepting attitude, can create a more normal and tension-free atmosphere than can be achieved elsewhere in the hospital; this may be one of their most important functions.

Psychiatrists Provide Clues to Patient Needs

If it be essential for the activity therapist to reckon with his own needs, it is equally important for him to know the psychological needs of the patient and how to meet them. These clues must be provided by the psychiatrist. They will determine the selection of activity, the approach to the patient, and the management of the interpersonal situation.

Because the activity therapies are rooted in reality, they may provide a powerful aid in keeping the patient in touch with his surroundings. The tasks provided may demand some of the attention usually given to fantasy and introspection. A careful choice of occupation may be able to help a patient sublimate hostility, aggression, and guilt.

Healthy activities give opportunities for impulse control, mastery of new skills, pattern achievement, and realization of constructive and creative goals. The activities are not simply auxiliary services to provide diversion on a ward, but must be viewed and used as primary forces for therapy-functioning in an integrated total program. Activity is the laboratory in which the patient can try out what he may learn in psychotherapy.

Activity Staff Considers Individual Tolerance

It is the duty of professional activity staff to temper the reality situation to the tolerance of the individual. The activity therapist may be the only one who is able to understand and deal effectively with a patient's attitude and behavior at any particular time. He or she may not be prepared to interpret material from a patient, but should remember the value of material freely given, and use this for discussion with the psychiatrist in an effort to better understand and meet the patient's needs.

Insofar as all interpersonal influences are important in the therapeutic process, activity workers must be considered as a significant part of the clinical team engaged in a common effort. Their inclusion in the team provides a better integrated ward program and creates a more uniform attitude of the whole staff, beneficial to the patient.

It is important to remember that the conditions for maximally effective total collaborative staff therapy can exist only in a setting that has competent administrative and professional leadership. It is the direct responsibility of the psychiatrist to provide such leadership and intelligently use the services of activity personnel for the optimum benefit of patients.

Preliminary Program Topics and Leader

Hotel Statler, Buffalo, New York

Monday, October 19th

SPECIAL SECTIONAL MEETINGS

9:00 a.m. — 5 p.m.

MENTAL HEALTH EDUCATORS. (Room to be announced.)

Mr. Alex Sareyan
Mental Health Materials Center
104 E. 25th St., New York 10, N. Y.

9:00 a.m. — 5:30 p.m.

PSYCHIATRIC NURSES. (Room to be announced.)

Miss Tirzah Morgan
Psychiatric Nurse Consultant
Hospital Consultation Service
Community Services Branch
National Institute of Mental Health
Bethesda 14, Maryland

9:00 a.m. — 5:00 p.m.

DIRECTORS OF VOLUNTEERS. (Maple Leaf Room)

Mrs. Miriam Karlins
State Coordinator of Volunteer Services
Department of Public Welfare
117 University Avenue, St. Paul, Minn.

10:00 a.m. — 5:00 p.m.

HOSPITAL BUSINESS MANAGERS. (New York Room)

Mr. Alexis Tarumianz
Business Manager
Delaware State Hospital
Farnhurst, Delaware

1:30 p.m. — 5:00 p.m.

NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS (Los Angeles Room)

Dr. George W. Jackson
Director of Institutions
Department of Social Welfare
Topeka, Kansas

(Subcommittee meetings 8 a.m.-12 noon)

If you plan to attend any of these meetings and wish further information, please contact the people whose names and addresses are listed above.

8:00 p.m. — midnight

"Early Bird" Cocktail Party in the Terrace Room

Tuesday, October 20th

PLENARY SESSION

9:00 a.m.

Opening of Plenary Sessions and Address by the President of the A.P.A., William Malamud, M.D.

9:45 a.m.

Keynote Address on Main Topic of Institute:

"The Psychiatric Problems of the Aging and of the Aging Mental Defective," Leo H. Bartemeier, M.D., Baltimore, Md.

10:15 a.m.

"Clinical Problems Underlying Administrative Practices in Treatment and Care of the Aging Patient," Ewald W. Busse, M.D., Durham, N. C.

11:45 a.m.

The whole assembly will divide into two sections, which will go their separate ways until Thursday morning, October 22 at 9 a.m. One section consisting of 150 people will be subdivided into 8-10 PILOT GROUPS. The remainder of the participants will constitute the MAIN GROUP.

PILOT GROUPS

1 p.m. — 4 p.m.

Each of the Pilot Groups will discuss individually the main topic of the Institute: **"The Psychiatric Problems of the Aging and of the Aging Mental Defective."**

MAIN GROUP

1 p.m. — 4 p.m.

Discussion of the main topic of the Institute: **"The Psychiatric Problems of the Aging and of the Aging Mental Defective."** Leo H. Bartemeier, M.D., Baltimore, Md., Discussion Leader.

6:30 p.m.

Cocktail Party, Annual Dinner, Presentation of the Mental Hospital Service Achievement Awards.

8:00 p.m.

ACADEMIC LECTURE: "Economics, Ethics, and Mental Illness." The Hon. John E. Fogarty, U. S. House of Representatives, Chairman, Subcommittee on Labor, Health, Education and Welfare.

...or Eleventh Mental Hospital Institute

...tober 19 through 22, 1959

Wednesday, October 21

PILOT GROUPS

9 a.m. — 12 noon

Resumption of individual group discussions of main topic: **"The Psychiatric Problems of the Aging and of the Aging Mental Defective."**

1 p.m. — 4 p.m.

Resumption of morning discussions.

4 p.m. — 5 p.m.

Leaders of the Pilot Groups meet in caucus to select several of their number to present reports to the Main Group in Plenary Session on Thursday morning.

MAIN GROUP

9 a.m. — 12 noon

Topic: **"Liberalization of the Care of the Mentally Ill and the Mentally Deficient."** Robert E. Bennett, M.D., Princeton, New Jersey, Discussion Leader.

1 p.m. — 4 p.m.

SIX SIMULTANEOUS SESSIONS:

Topic A: **"The Medical Audit"** Lee G. Sewall, M.D., Perry Point, Md., Discussion Leader

Topic B: **"Roles of the Psychologist and Social Worker"** William Hunt, Ph. D., Chicago, Ill., Discussion Leader

Topic C: **"Employees' Organizations and Unions"** Mr. Granville Hills, Albany, N. Y., Discussion Leader

Topic D: **"Eugenic Practices in Hospitals for the Mentally Ill and Mentally Deficient"** Gordon Allen, M.D., Bethesda, Md., Discussion Leader

Topic E: **"The Present Status of the Open Hospital"** C. F. Terrence, M.D., Rochester, N. Y., Discussion Leader

Topic F: **"Remotivation"** Robert S. Garber, M.D., Belle Mead, N. J., Discussion Leader

Thursday, October 22

9:00 a.m. — 12 noon

FULL PLENARY SESSION for Pilot Groups and Main Group. Selected leaders of Pilot Groups will present reports of their individual deliberations on the main topic: **"The Psychiatric Problems of the Aging and the Aging Mental Defective."**

1:00 p.m. — 3:00 p.m.

PLENARY SESSION FOR ALL PARTICIPANTS: "Hospital Psychiatry Meets the Press"

1:00 p.m.

A panel of newspaper men will question a selected group of hospital psychiatrists on the general topic: **"Are We Making Progress Against Mental Illness?"**

2:00 p.m.

A group of psychiatrists will question the press on the topic: **"The Press—Help or Hindrance in Fighting Mental Illness?"**

"Questions From the Floor" addressed to either group or both.

More Information about the Institute

The new format adopted for the Eleventh Mental Hospital Institute is designed to solve the ever-increasing problem of obtaining wider audience participation in the discussions.

No requests to join the Pilot Groups will be entertained. A subcommittee of the Program Committee will make the selections, based upon certain specific criteria, early in September from registrations already received. Those selected will be advised by letter.

With the assistance of the A.P.A. Committee on Aging, resource material is being gathered on the major topic of the Institute for use by discussion leaders of Plenary Sessions and Pilot Groups. MENTAL HOPSITALS will continue to publish articles on aging, and some Supplementary Mailings are also in the course of preparation.

Monday, October 19, will be devoted entirely to Special Sectional Meetings, and the Local Arrangements Committee is planning some visits to local hospitals for Monday afternoon.

Inspecting the X-Ray Department

By CHARLES K. BUSH, M.D.

Chief Inspector, A.P.A. Central Inspection Board

IN THE RATING of public hospitals, the X-ray department is one of the nine departments considered essential by the Central Inspection Board. In the rating of private hospitals, it is a part of Medical Services, which is one of the seven essential departments.

In public mental hospitals, the X-ray department should meet the minimum requirements that were adopted by the A.P.A. Committee on Standards and Policies of Hospitals and Clinics from the standards delineated by the Joint Commission on Accreditation of Hospitals. These requirements are:

1. The hospital must maintain radiological services according to the needs of the hospital.
2. The radiology department should be free of hazards for patients and personnel.
3. The interpretation of radiological examinations should be made by physicians competent in the field.
4. Signed reports should be filed with the patient's record and duplicate copies kept in the department.
5. Reports should be indexed according to radiological diagnosis.

The location of the X-ray department should be as near as possible to those wards which use the service most and this generally means the medical and surgical wards. Adequate space must be provided for an office, treatment room (s), dark room, dressing rooms, toilets and work space. The equipment should be of at least 200 milliampere capacity and facilities for fluoroscopy and spot films are desirable. A portable machine which can be used to take bedside X-rays is recommended. Equipment should be shockproof and in an area free from fire and explosion hazards. Even though safety film is now being employed almost exclusively, used films should still be stored in metal cabinets of some type and not on open wooden shelves.

Extra Equipment Requires Special Precautions

Equipment for superficial and deep therapy and radium therapy is not considered a necessary part of the X-ray department. If such equipment is used, it should be carefully regulated and extra precautions are necessary to protect both the patient and the operator. Special precautions are also required if fluoroscopy is used.

Personnel of the X-ray department should have blood counts made at least every six months and some type of radiation-exposure detector should be worn. Walls, ceilings, floors and doors require lead-lining to protect persons in adjacent areas and these areas should be checked occasionally for radiation.

In hospitals of 3000 beds or more, a full time radiologist, board-certified or at least board-eligible, is recommended. Where there are less than 3000 beds, full credit is given for a part-time radiologist. In very small hospitals, it is considered satisfactory to have a consultant who makes regular visits to the department and examines and reports on all films. All reports must be signed by the radiologist, or rubber-stamped by him if he has certified in writing to the superintendent that he alone has possession of and uses the stamp.

There should be at least one technician who is registered with the Association of Registered X-ray Technicians or is eligible for registration.

Standards for Private Hospitals

X-ray departments in private psychiatric hospitals which have them are required to meet the same standards as those in public hospitals. If the hospital does not have its own X-ray department, such services should be available in a nearby approved general hospital and there should be evidence that the service is sufficiently used. X-ray services either at the hospital or in a convenient general hospital should be available at night, on week ends and on holidays.

In order to quickly detect cases of tuberculosis and malignancy of the lung, it is recommended that all patients have a chest X-ray on admission and at least yearly thereafter as long as they remain in the hospital. Many hospitals do an annual or semi-annual survey of all patients who have been in the hospital longer than three months.

All requisitions for X-rays should be in writing and should contain the physician's note of physical findings and any suspected lesion. The more specific the request and the more complete the information, the better the radiologist will be able to do his evaluation.

Records should, of course, be kept of all X-ray work accomplished and monthly and annual reports made to the superintendent or medical director.

DIGGING THEIR TROUBLES INTO THE GROUND

Through gardening, troubled young people at Pontiac (Mich.) State Hospital are learning to grow out of themselves, to build relationships, to participate actively in life. Mrs. William H. Burlingame, a psychiatric social worker and occupational therapist, is conducting weekly a rewarding rehabilitation program through horticulture for about 450 patients of all age groups.

The program is especially useful for youngsters who tend their own little plots of land, thus acquiring the sense of importance and accomplishment so necessary to rehabilitation. A group of forty boys, committed as delinquents and criminals, are now associated with a 4-H Club garden project and compete at county fairs. Working with each young gardener is a volunteer from the community who gives love and support, a sense of belonging and worthwhile achievement to every child.

Of the children's gardening program, Dr. James McHugh, a staff psychiatrist, states: "When these youngsters enter the hospital, they come rejected by their communities. They regard the hospital as a 'one-way door.' Within a short time, they have a garden, and their efforts are praised and acceptable. This program, through giving them a new level of participation, brings them out of the cycle of feeling that they are unworthy, for the growing flowers and vegetables are dependent upon them.

"To place emotionally disturbed persons out in a garden is good In this setting, space opens up and they no longer feel hemmed in. They can run, shout, and release the factors which have molded them into incorrigibles. In a literal sense, these children are digging their troubles into the soil."

So effective is the horticultural therapy at Pontiac that similar programs are planned for other institutions of various types.

VISUAL AID TO REMOTIVATION

An attendant at the Brooklyn (N.Y.) State Hospital uses a novel method to introduce the Remotivation technique. Mr. John E. Angelone presents the display shown at right as a visual aid to his conversation with the patients.

At the top of the wooden case (here shown open) the word Remotivation lights up to set the stage for the illustrated project. On the shelf below this, the hospital team in the center is a link between the patient on the left and the world on the right. In the center of the cover are listed the five steps used in the program. The battleship on the lower shelf represents the topic of the day. In the bottom part of the case, the same five steps are described in a more tangible form by using small figurines. The circle at lower center represents the aide conducting his project with the patients around him.

The meeting is structured around the five steps of Remotivation:

In Step 1, *Climate of Acceptance,* the aide greets the patients and introduces himself. In turn, each one is asked to give his name. Step 2 provides a *Bridge to the World of Reality* when the aide poses questions related to the topic of the day (battleship). For instance, he might ask "By what other name is a warship known?" In Step 3, *To Share The World We Live In,* the group is asked to name other types of ships, ranks of naval officers, navigational instruments, etc., and tell what kind of war material is found on a battleship. Step 4 relates *The Work of The World* to the different types of occupations aboard ship. Participants are asked which jobs they would prefer and why.

In Step 5, the last step, a *Climate of Appreciation* is created by the aide, who summarizes the topic of discussion, thanks the patients and tells them how much he has enjoyed the meeting.

VA HOSPITAL RECOGNIZES OUTSTANDING PATIENTS

The Veterans Administration Hospital at Fort Meade, South Dakota, recognizes patients' outstanding work performances with certificates of commendation and a special treat.

The staff has long been aware of the lack of such recognition in mental institutions. They feel that, just as performance rating plans in industry and government permit formal acknowledgment of the superior worker, something more than a good word and a pat on the back is needed to reward a patient for the excellence of his work.

A few years ago a system was devised by which the industrial therapy supervisor can grade patients and recommend them, with the approval of their physicians, to a nominating board for special recognition. The selection of the most deserving patients is done on the basis of achievement, flexibility, motivation for extra-hospital adjustment, initiative, and interest in helping others.

VETERANS ADMINISTRATION HOSPITAL

Certificate of

Outstanding Service

Awarded to

In recognition of his ability to carry out assignments and show progressive betterment of Service and Self.

Awarded at VAH, Fort Meade, S. Dak.

on_____19_____

_____

Manager

The first presentation of certificates took place during the intermission of the regular weekly dance. Later the recipients of the awards were taken for a motor trip to Mount Rushmore Memorial, a visit to the museum and a dinner there. The families of the selected patients were notified of their accomplishment and received a duplicate certificate. These certificates (see accompanying illustration) are made by the Manual Arts Therapy print shop.

The event was so successful that it was repeated the following year and has now become a part of the annual hospital activities.

MICHAEL A. CIELUSAK, Chief, Special Service
HERBERT S. SAMUELS, A.M.L.S., Chief Librarian

Christmas is Coming

Although it may seem to most of us that December is a long way off, the Christmas season starts in July for a group of volunteers in Minnesota. The handling of Christmas presents has always been somewhat of a problem to many hospitals because of the additional burden it puts on the staff. The Auxiliary to the Veterans of Foreign Wars, operating at the Willmar State Hospital, has for many years used a system, which, if it does not entirely solve the problem, alleviates it considerably.

In July or August, the group sends Christmas-letter forms (one for each patient) to all wards, and the ward staff checks items the patients would like to receive for Christmas. These forms are completed and collected sometime in September and mailed out early in November to patients' relatives and friends who are requested to have their packages reach the hospital no later than December 15. The Auxiliary then gift-wraps and prepares them for distribution on Christmas day. This method has done much to avoid the last minute rush.

Michigan Theatre Chain to the Rescue

When the director of recreational therapy at Traverse City (Mich.) State Hospital informed the community relations director that the movie equipment, in use since 1923, was broken down beyond repair, there was considerable consternation. Movies are a very important part of patients' recreational activities at the hospital, and the closing down of the theatre meant a real loss. The community came to the rescue and solved the dilemma.

On hearing of the situation, Mr. Paul Seippel, vice-president, and Mr. Warren Wardwell, local manager of Butterfield Theatres Inc., came to the hospital to see what could be done with the available facilities. As a result of this visit, the theatre chain provided the institution with two Simplex projectors, complete with sound booth and stage equipment, a gift worth several thousands of dollars.

However, when the hospital acquired this fine gift, it also acquired some problems. This modern apparatus would not fit into the old-fashioned projection booth and this called for extensive remodeling. The hospital maintenance crew, under the expert guidance of Mr. Robert H. Bunting, an RCA field engineer who gave freely of his time, enlarged the projection booth, changed the electrical wiring, installed transformers and rectifiers, and so on. The actual installation of the projectors was done with the help of Mr. Phil Tafelsky of the local A. F. of L. Operators' Union. A cinemascope screen was set up to complete the modernization and thus

provide the patients with the finest and most recent films.

This experience at Traverse City is an outstanding example of community participation in state hospital activities.

Closed Ward Holds Open House

A closed unit for women at Patton (Calif.) State Hospital recently held an "open house" which was quite different from the receptions held annually at the institution when the general public comes to visit the hospital grounds and certain selected sections. Invitations this time were limited to relatives of patients on the closed unit. It gave families an opportunity not only to see their own patients in the therapeutic milieu, but also to visit with other patients and their relatives and with the staff. Patients acted as hostesses, showing the visitors around, introducing members of their families to others, and serving refreshments which they had prepared themselves. They took evident pride in doing this for their families. Relatives shared a feeling of warmth, understanding, greater acceptance, and lessening of fear.

Knowing that these were relatives, patients were relaxed and comfortable. They liked the idea; in fact they formulated the plan. They therefore wanted to take an active part in its realization and extend the therapeutic community beyond the unit boundaries to their families in the outside world.

ARMAND MAZZUCA
Psychiatric Social Worker

Small Scale Golf A Big Success

Patients at the VA Hospital in Coatesville, Pennsylvania, have taken up miniature golf and the results are proving therapeutic as well as enjoyable.

Sports personnel of the hospital, seeking to adapt their programs to meet the needs of more patients improved with the advent of the tranquilizers, hit upon the idea of a miniature golf course to be constructed, used, and maintained by the patients themselves. A casual poll revealed that only six patients out of fifty had ever seen such a course, and only two had actually played on one. Accordingly, a bus was secured and visits were made to several commercial courses. Patients with mechanical drawing ability were invited to submit designs and ideas, and a course was laid out on the hospital grounds by the sports personnel. Material was provided by the Special Services Division. The only professional mechanic who worked on the course was the station stone mason who built a small retaining wall for one of the holes. Patients who had participated very little in other activities gave freely of their skills to this project, which was scheduled into their treatment program as assigned work periods.

At the same time as the miniature golf course was being constructed, a full scale driving range was being laid out and turned over to another ward group. In this instance the work was scheduled by full days rather than by shorter periods, thus providing the staff with a contrast to test the effectiveness of the two methods of assigning work time. Each patient participating in the activity at the golf range is provided with a bucket of 22 golf balls, a club of his choice, and a commercial ball retriever with which he recoups his own golf balls when he has finished driving them.

Although both the miniature golf course and the driving range are presently in use, neither project is completed. Maintenance is constant and improvements are always being made. Staff members believe that these activities have definite carryover value following hospitalization. They do not require great skill to enjoy and they provide pleasurable entertainment for family and friendly groups as well as for individuals.

JOHN G. MAURER
Sports Supervisor

Kardex Filing System Provides Quick Reference on Outpatients

A KARDEX Filing System, located in the Outpatient Clinic office of the St. Louis State Hospital, has proved to be of great help in providing a quick source of reference on patients and their payment of fees, and in compiling statistical reports.

On the occasion of each patient's first admission to the clinic, a card designed specifically for use in our clinic is made out and filed alphabetically. The heading of each card includes the patient's name, clinic number, phone number, address and vital statistics, as well as the names of all of the clinic personnel with whom he has had some professional contact (e.g. therapist, psychologist for testing, social worker, etc.).

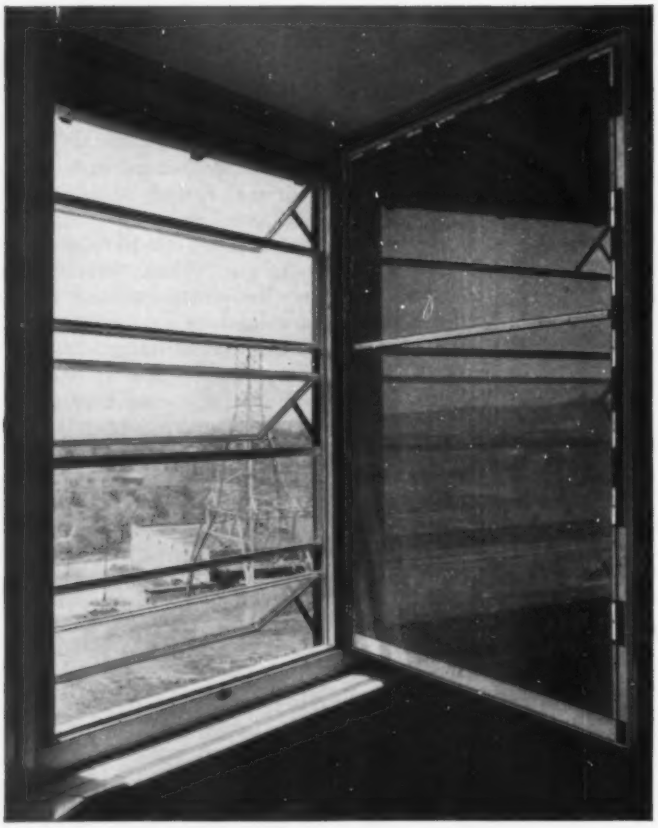
The bottom line of the card, which is the only exposed part when it is placed in the sliding drawer of the filing cabinet, can be equipped with one-quarter-inch colored translucent tabs. The clinic uses green ones to indicate patients who are active during the current month and white for those who are inactive, so that one can tell at a glance the active case load at that time. Along with the patient's name and date of admission, the bottom line is provided with several squares which indicate the type of activity being carried on when the tab is placed over the relevant square.

The bulk of the card is devoted to a miniature balance sheet on which the date of each visit, the amount paid and the amount owed can be recorded.

When the case is terminated, the card is placed in an inactive file. If the case is re-opened, the card can easily be replaced in the active file and the date can be recorded on the section provided for re-admissions.

If the cards are kept up-to-date, they can facilitate the compilation of such statistical information as the number of therapy interviews during the month, the case load of the individual therapists, the number of cases closed and re-opened, etc. They are also a handy source of information on patients' phone numbers, addresses and fees. The file's location in the clinic office makes it readily available to both professional and clerical staff who may need the information it contains without betraying the basic confidences of the patient's private record.

JEROME H. ZIMMERMAN
Intake Caseworker



The detention screen, used with this Truscon Intermediate Louver Window, is the principal restriction against injury and escape. Screen can be opened only by authorized use of a removable key.

These Truscon Intermediate Louver Windows offer 50% ventilation, are particularly suited to the needs of mental hospitals. A similar design provides 100% ventilation. Ventilators operate simultaneously.

Eastern Pennsylvania Psychiatric Institute, Philadelphia, Penna.; Harbeson, Hough, Livingston & Larson and Harry Sternfeld, Architects.

TRUSCON DETENTION WINDOWS combine apartment-like beauty with complete protection and safety

It's hard to believe from the casual, inviting appearance of these handsome Truscon Intermediate Louver Windows that they provide detention. That's because they're designed to conceal or minimize any appearance of enforced restraint. At the same time they're carefully engineered to protect mental patients against self-injury and to prevent escape.

Like all Truscon Steel Detention and Psychiatric Windows, they make maximum use of large total glass and ventilating areas for abundant healing sunlight and fresh air. Yet, they provide all the necessary margins of safety.

The degree of restraint can be entirely controlled by authorized personnel who operate the windows by a small removable crank—open or close the detention screens (above left) with a removable key.

You can benefit from Truscon's extensive specialized experience in the design and construction of steel windows for safe confinement of mental patients. Simply ask your nearest Truscon® representative for technical assistance. Catalog includes complete specifications. Send coupon for free copy.

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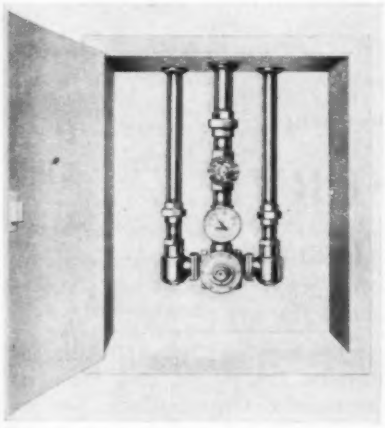
HOT WATER SAFETY IN MENTAL HOSPITALS

By CHARLES E. GOEHEN, M.D.
A.P.A. Architectural Service
and L. ASHLEY RICH
The Powers Regulator Co., Washington, D.C.

TOO FREQUENTLY, the patients of mental hospitals are subjected to a hazard which is relatively easy to prevent—danger from the hot water supply. Unfortunately, the burns which result from scalding water seldom receive much attention or publicity, and are therefore not generally recognized as part of a problem which demands a solution.

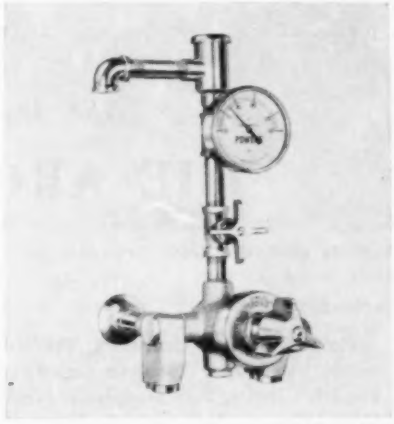
Elderly and mentally defective patients are particularly liable to the hazards of excessively hot water in bathing facilities, and since much of today's new construction is for the purpose of housing these groups, it would be wise to include plans for automatic controls. Automatic, thermostatic controls are now available and represent practical ways of insuring safe water temperatures.

Thermostatic hot water controls are devices which are installed in hot water supply systems to control the mixing of hot and cold water in such a way as to produce water of constant, predetermined temperature. Such controls are most useful in showers, baths, hydrotherapy units, operating rooms, kitchens, and utility rooms.

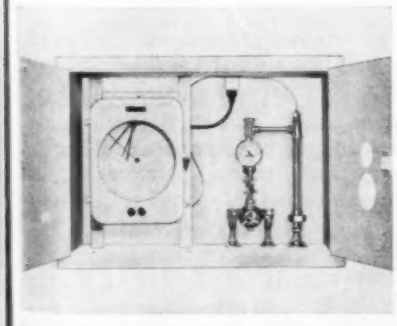


Cabinet-type control for gang showers.

Concealed thermostatic mixing valve with vandal-proof accessories.

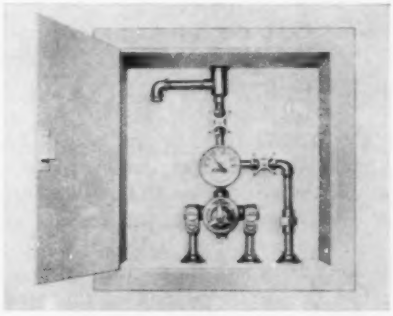


Thermostatic mixer (with vacuum breaker)



Recording control for continuous flow baths.

Exposed thermostatic mixer with strainer and automatic checks to prevent back-flow.



Cabinet control for lavatories and showers.

Several variables are involved in determining the temperature of hot water at the outlet point. The amount of water being used influences the rate of consumption of the hot water supply and therefore its temperature. The line pressure in the total water system influences it. The distance the hot water has to travel from the point where it is heated to the point where it is used determines the amount of heat lost. The temperature of the incoming cold water will vary during different seasons of the year. These load factors must be considered in choosing the particular type of temperature regulator which is to be used.

Some types are capable of handling more variables over a wider range than others. As with most other mechanical contrivances, it is important to install high-quality devices, even if the initial cost is more, in order to insure high-quality performance and low maintenance.

Following is a suggested way of writing specifications for thermostatic controls in order to minimize the possibilities of obtaining inferior equipment.

Spec: *Hot Water Generator Temperature Control*

Steam at —— p.s.i. shall raise the temperature of water from minimum street temperature of ——°F. to control temperature of (suggested) 140°F. Hot water temperature in the generator shall be controlled by a regulator which shall have:

1. Factory representative guarantee that the regulator is of proper type, range and capacity to meet all existing conditions in the installation as well as above specifications as to size.
2. Bronze body with unions and stainless steel trim (above 2½" iron body flanged and bronze trim).
3. Indicating type operating part with bronze bellows at least 4" in diameter. Stainless steel stem, override protection, lubricator in stem.
4. A written 2-year guarantee to provide repair or replacement.

Spec: *Thermostatic Mixing Valves*

Shall mix hot and cold water to supply tempered water at a temperature which will be thermostatically controlled to vary less than 2°F. from the adjustable water temperature desired. This temperature shall be maintained constant even though inlet temperature of hot water varies 50°F., inlet pressures hot or cold vary 75%, outlet water volume is variable up to 85%. Thermostatic valve shall have an internal adjustment so that no water hotter than (suggested) 100°F. can pass the valve under any conditions whatsoever, including failure of the thermostatic bellows to function. A two-year guarantee for parts and service shall be provided.

Recommended sizes:

10 g.p.m. at 45 p.s.i. inlet pressures for showers and tubs.

20 g.p.m. for 3 to 5 lavatories or showers.

40 g.p.m. for up to 10 shower-heads, gang type.

120 g.p.m. for 10 to 30 shower-heads, gang type.

The American Psychiatric Association Announces

THE ARCHITECTURAL SERVICE

A new consultation service for the planning, designing and equipping of psychiatric facilities

Including:

Public Mental Hospitals, Private Psychiatric Hospitals, Psychiatric Units in General Hospitals, Mental Health Clinics, Day Hospitals, Night Hospitals, Half-Way Houses, Sheltered Workshops, Residential Units for Children, and Special Facilities for the Aging.

This service is available to:

Architectural and Engineering Firms, Heating and Lighting Manufacturers, Equipment and Furniture Manufacturers, Community Organizations, Government Agencies, Hospital Planning Commissions and Related Groups.

Since 1953, the A.P.A., in cooperation with members of the A.I.A., has collected a considerable body of data on the environmental needs for psychiatric care and has defined operating principles.

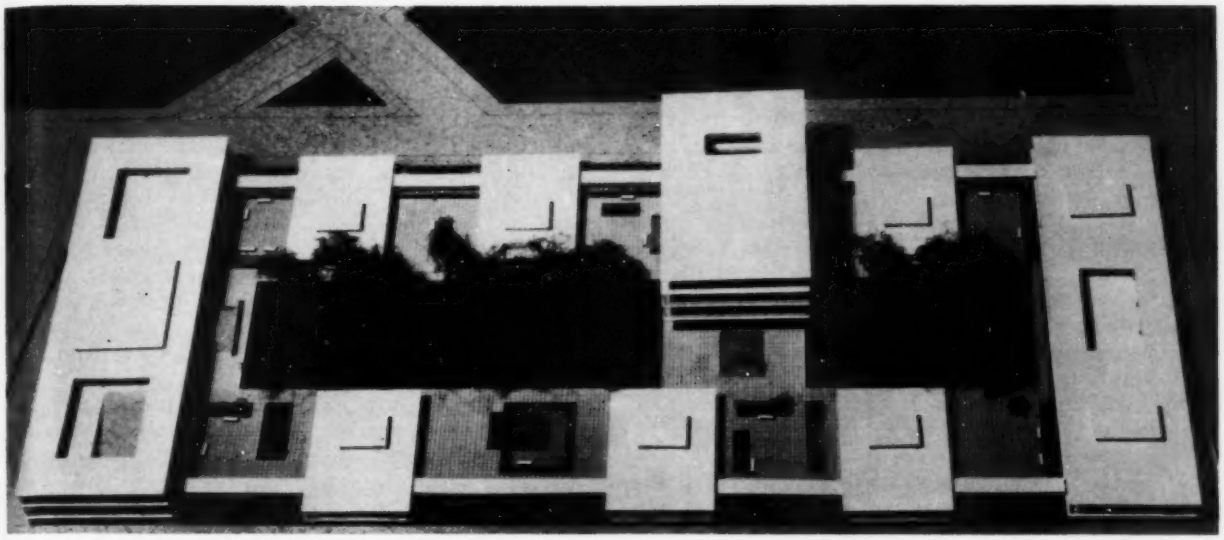
The A.P.A. Architectural Service has been established to make these data available and to apply them specifically to individual projects. The Service will be of the greatest value during the earliest stages of planning. Consultation will include an on-the-site visit and discussions between the planning groups, the architects and the professional staff of the consultation service.

"Design Clinics," consisting of two- or three-day seminars, will also be held for limited numbers of architects and the administrative groups charged with planning. The primary purpose of these seminars will be a general appraisal of the design of specific psychiatric facilities.

The grant-supported study phase of the original project has terminated, and the new Architectural Service will be self-supporting. Consultation, therefore, will be furnished on the conventional fee-for-service basis plus travel expenses.

For Further Information

Write to Mathew Ross, M.D., Medical Director, American Psychiatric Association, 1700 Eighteenth St., N.W., Washington 9, D.C.



AWARD WINNING DESIGN FOR MENTAL HEALTH CENTER

By BRUCE P. ARNEILL
Yale University School of Architecture
New Haven, Connecticut

THE PROGRAM PRESENTED to each student in the third year of Architectural School at Yale University was basically to design a 150-bed "New Haven Mental Health Center" with teaching facilities, on the site adjacent to the Yale-New Haven Medical Center. The requirements were diverse and intricate and strongly emphasized the trend away from custodial care. Specific details were:

1. *General Purpose:* The Mental Health Center is to be a functional unit of the Grace-New Haven Hospital, to be located on a city block adjacent to the main hospital, and connected by tunnels for certain services. In addition to its function as an inpatient psychiatric service, it is to provide outpatient services, teaching facilities, and administrative services. The over-all theme determining the choice of design is to be two-fold: it is to provide treatment and teaching facilities in a way which will best include an environment conducive to socialization and re-culturization and, in addition, it is to convey to the public at large a desirable and understanding attitude toward psychiatric care.

2. *Site:* The site is to be a city block, approximately 620 ft. by 160 ft., rectangular in shape, and flat.

3. *Size:* Provision is to be made for sufficient flexibility to allow expansion to 150 beds, although initial plans are for building a smaller unit. Major services in the way of heat, food, etc. are to emanate from the main hospital.

4. *Inpatient Facilities:* Provision is to be made for an eventual capacity of 150 beds. Present plans call for six nursing units of 15-20 beds each. One section is to provide facilities for intensive nursing care, with four single bedrooms, two seclusion rooms and two four-bed rooms. The other sections will be open wards of 20-bed units.

5. *Outpatient Department:* Facilities are for a total six-hour load of 120 people with space for as many as 20 at one time, and 25 offices. Total floor space to be about 4600 sq. ft.

6. *Staff Facilities:* This area is to provide administrative and teaching space, including an admitting office. About 1000 sq. ft. are needed for reception services, 2300 sq. ft. for business administration, 200 sq. ft. for an admitting office, 3400 sq. ft. for medical administration, 500 sq. ft. for nursing administration, 500 sq. ft. for psychologists, 1000 sq. ft. for social workers, 850 sq. ft. for doctors' personal facilities (lounge, library, etc.), 400 sq. ft. for nurses' personal facilities, 400 sq. ft. for attendants' personal facilities, and space for emergency admissions.

7. *Education Facilities:* This section is to include an

auditorium seating 200 with a stage, three classrooms for 15 students each, and seminar or conference rooms near each department.

8. *Adjunctive Treatment Facilities:* These are to include a laboratory, X-ray room, electroshock room, electrocardiograph room, basal metabolism room, dressing rooms, and waiting area.

9. *Activities (Indoor) Area:* These are to be co-educational facilities for recreation and occupational therapy. They are to include: reception area, social room, library, music room, barber shop, beauty shop, gymnasium, woodworking shop, weaving shop, ceramic work shop, print-photo shop, art studio, kitchen (patients'), storage and supply space, dining area, chapel and greenhouse.

10. *Activities (Outdoor) Area:* These are to include a swimming pool with dressing facilities, picnic area, promenade, etc.

11. *Service Area:* This space will provide for dining (maximum of 40 people at one time), reception and storage of supplies, parking, heating, ventilation, air-conditioning, parking and personal facilities for non-professional staff.

Serenity and simplicity leading to a measure of security were my greatest aims in designing this community within a community, to create an abnormally normal environment where people would feel at ease and would know where they were by the location, use, expression, and scale of each building.

Peripheral Buildings Imply Security

One of the major detriments to a pleasant and friendly atmosphere in such a center is the enclosing of the complex by walls. Therefore, I decided to imply an atmosphere of security by the peripheral location of buildings connected by a glazed and louvered corridor, which would be used primarily by the staff and for emergencies. This part would allow the patients to have absolute freedom within the complex and enable them to see out so that they would not be totally removed from the world around them. At the same time it would allow the people on the outside to gain an impression of the central spaces within the complex.

Each element of the complex is composed of one or more 16′ by 20′ rectangles to give a simple and inexpensive structural system. The entire complex is raised onto a three-foot platform so that light and air can enter the service tunnels and basement areas, and to define the main entrance to the center. The first floor of the office building is the main entrance and exit for the whole center. It contains an information and small admission area and a large lounge for everybody, including visitors who wish to see such a center.

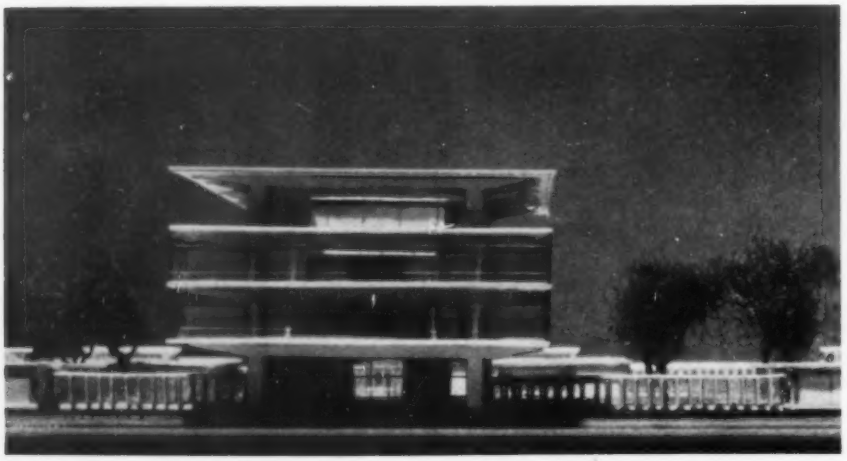
The open nursing units are used to make a variety of intimate courts along the large mall and also to break up the monotony of the regular grid system. Each of them contains four single rooms and four 4-bed rooms, all of which look out and have access to the courts. The lounges in the nursing units look out at the mall and are used as the main entrances.

The two intensive-care units are at the end of the mall and raised slightly above the main platform height. Both look out and have access to a large court, which is an indirect extension of the main mall. Below these units are the emergency admitting, doctors' parking, and tunnel entrance from the Medical Center.

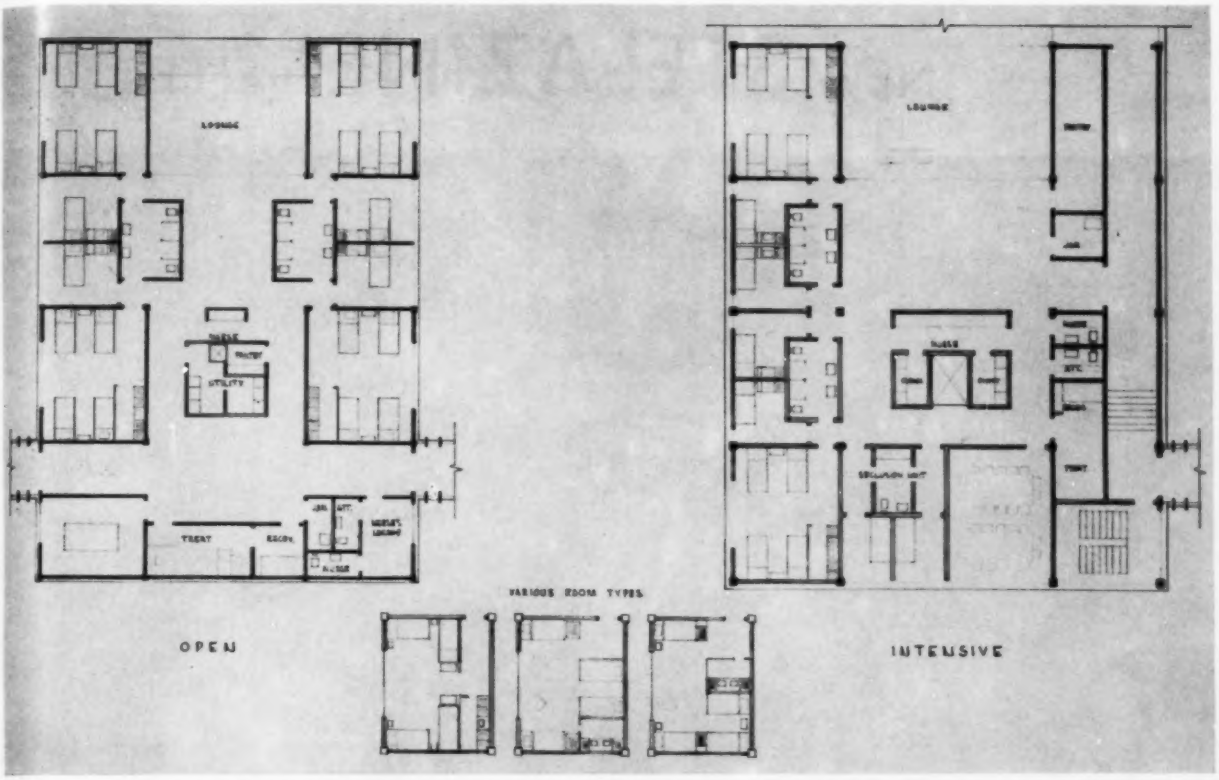
The adult activity building at the other end of the mall provides for all the more therapeutic and recreational functions. The top floor is rather open and contains the main dining room, gymnasium, and swimming pool, which can be open in the summer and closed in the winter. On the main floor, slightly higher than the platform, are located the smaller functions and auditorium. Below this floor are the service areas, tunnel from the Grace-New Haven Hospital and the centralized kitchen, and parking for nurses and visitors.

A strong tenet that patients should lead as normal an existence as possible prohibited their being stuffed into one building with all of their daily activities at their finger tips. Instead, all of these facilities have been placed in separate units, designed to express their separate functions, and located around the mall so that patients can walk or stroll to their various destinations in any kind of weather.

From a personnel-recruiting standpoint, it is my firm



The first floor of the office building serves as the main entrance and exit for the entire center. It contains an information and small admission area and a large lounge for everybody, including visitors who wish to observe such a center.



Open nursing units (left) contain four single rooms and four 4-bed wards. Intensive-care units (right) include four single bedrooms, two seclusion rooms and two 4-bed wards. Flexibility of room arrangement is illustrated at center.

belief that good mental health centers with non-institutional atmospheres and pleasant and healthy environments, developed in cities where people can see them and have convenient access to them, will create broadened understanding and increased interest in psychiatry and its related fields.

COMMENT

CHARLES E. GOSHEN, M.D.
A.P.A. Architectural Service

Architecture has achieved a remarkable degree of progress since World War II. This has been due to a number of factors, not the least of which has been the enormous demand for new buildings. In addition, the design of buildings has been liberated from the restrictions imposed by older construction methods, the principle of which was largely based on placing one brick on top of another. New materials, new skills, and new types of machinery have made possible a tremendous widening of the spectrum of sizes and shapes which can be built.

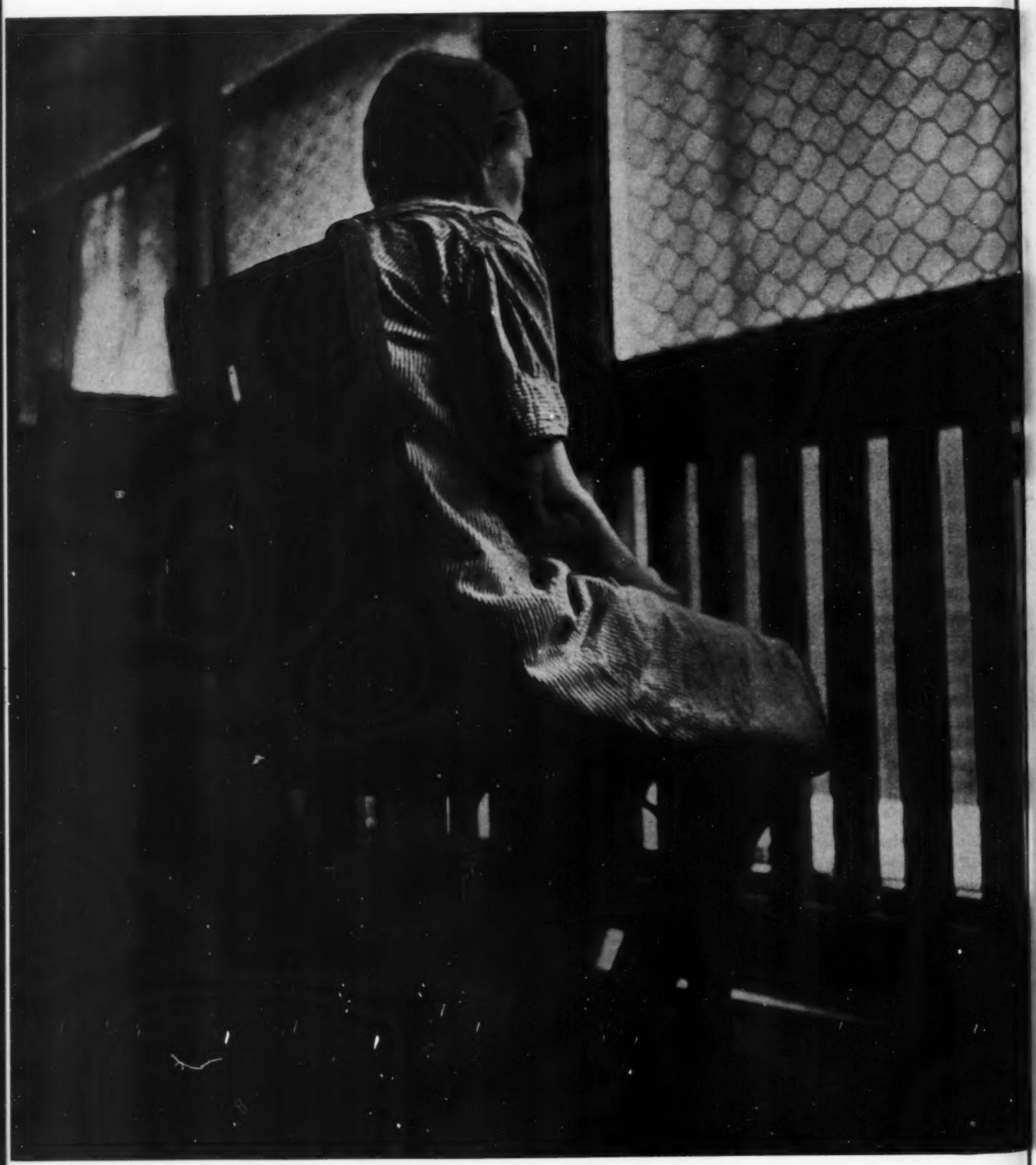
Very important, also, has been a general public awareness of the functional and esthetic concept of design, and a demand and acceptance on the part of the public for imaginative uses of new approaches. Interestingly, the types of buildings which have most daringly employed contemporary features have been schools, banks, factories and churches, whereas office and public buildings have been much less adventurous. One would have expected that the conservative tradition of banks and churches, particularly, would have delayed the acceptance of new ideas, but this has not been the case. In addition, there have developed entirely new classes of architecture where little in the way of precedent existed. This applies especially to the new type of suburban shopping centers and motels, both of which have made extensive use of the newest types of architectural thinking.

Psychiatric architecture has not tended to follow modern design to any appreciable extent, although there now exist a few noteworthy exceptions. Instead, the tendency has been to imitate the traditional architectural forms, and to follow the pattern established in the past of adhering to economy as the dominant theme in the choice of design.

Because the traditional forms of psychiatric architecture are so glaringly unfunctional and unesthetic in the light of today's technological knowledge, it is especially refreshing to find a new design which does not follow the tradition. Congratulations to Mr. Arneill, whose design for the New Haven Mental Health Center won the 1958 Magnus T. Hopper Fellowship Award at the Yale University School of Architecture.

NEW STELAZINE* EFFECTIVE IN

RE



IN CHRONIC PSYCHOTIC PATIENTS REFRACTORY TO OTHER THERAPIES

"It is obvious that we have in ['Stelazine'] a very effective drug which often produces results where other treatment has failed."

Gunn, D.R.: The Role of Trifluoperazine in the Treatment of Refractory Mental Patients, in Trifluoperazine: Clinical and Pharmacological Aspects, Philadelphia, Lea & Febiger, 1958, pp. 47-53.

"... the majority of patients treated—formerly considered practically hopeless—are now in some way more easily managed on the ward."

Klimczynski, J.J.T.: Treatment of Chronically Ill Psychotic Patients with Trifluoperazine: A Preliminary Report, *ibid.*, pp. 101-112.

"The relatively low number of failures of treatment, even in those who have been sick for a long time, must be considered almost as significant as the high proportion of good recoveries."

Goldman, D.: Clinical Experience with Trifluoperazine: Treatment of Psychotic States, *ibid.*, pp. 71-86.

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Multiple dose vials, 10 cc. (2 mg./cc.)

Literature available on request.

Smith Kline & French Laboratories (SKF) **leaders in psychopharmacology**

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ADMINISTRATI
Feature
Of The Monti

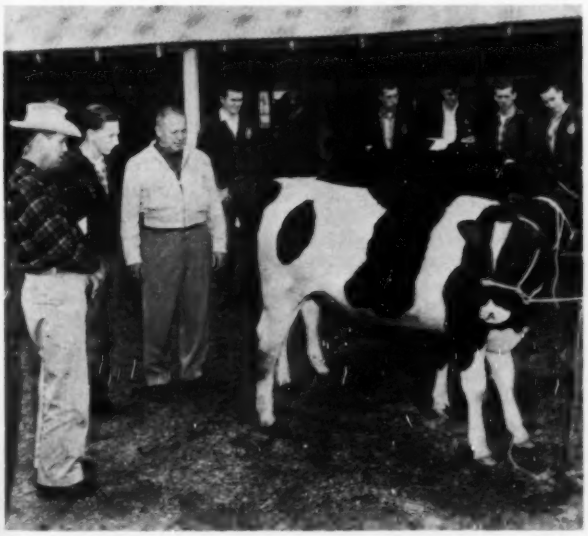
The Value of the Mental Hospital Farm

By JAMES N. EDWARDS
Farm Superintendent, Eastern State Hospital
Vinita, Oklahoma

THE VALUES OF A FARM to the mental hospital can be placed in two categories—monetary value and therapeutic value.

The monetary value is measured in terms of food produced and used by the hospital, and is therefore dependent on how economically food can be produced to meet the hospital's needs.

The therapeutic value of the farm depends largely upon the social culture of the people in the area which the mental hospital serves. The twenty-five eastern counties of Oklahoma served by the Eastern State Hospital are predominantly rural and approximately 80 per cent of our patients have a farm background. It is logical to believe that the patients benefit from job assignments on the hospital farm, doing work that is familiar to them.



Future Farmers of America and 4-H Clubbers hold judging workouts at the hospital farm. The author is at far left.

Our farm consists of two thousand acres of predominantly sandy-loam prairie land, located close to the institution. Because the soil is rich, the average yearly rainfall 43 inches a year, and the growing seasons long, the farm is contributing much of the food needs of the 2,400 patients. But possibly the greatest single asset the farm has is the wholehearted cooperation of the medical superintendent and the business manager of the hospital who understand and appreciate the farm's value, yet do not labor under the misapprehension that they know enough to qualify them to be farmers!

Of the 70 cents per capita daily food cost last year, 22 cents worth was furnished by the farm. In the last two years an average of 605 gallons of pasteurized milk were furnished each day at a cost of 44.5 cents a gallon. This milk is of high quality, testing 3.7% butterfat and never over 12 hours old when served.

Hospital Dairy Herd Outstanding

The success of our showing of the dairy animals and the outstanding production of our herd help in producing milk economically. Our animals are in great demand for breeding stock throughout the country. During the past two years we have sold 69 young herd sires for a total of $12,803. Some of these animals sold for as much as $1,200 a head and have been shipped as far as La Paz, Bolivia. Of the twelve mental institutions in Oklahoma, seven are using bulls from our herd. We have made weekly shipments of fresh chilled semen to several of the state institutions.

Disposing of the garbage from the various hospital kitchens could be a real problem, but feeding it to swine turns this into a money-making activity. The garbage is picked up daily, steam-cooked and fed to 250 head of feeder hogs. In the past two years we have produced 120,865 pounds of carcass pork at a cost of 20.5 cents a pound. The swine project is handled by one employee and two patients, with assistance from other farm employees only during butchering time.

At the present time the farm is furnishing an average

of 100 dozen fresh eggs a day and a biweekly serving of dressed poultry. The poultry business is probably the lowest per cent profit return of any farm department, so we cannot boast of the thousands of dollars we make each month. But we take pride in the fact that the dressed broilers are fresh and have not been injected with water to increase poundage and make the carcasses look more plump. We know our per cent of rotten eggs is nil compared to the usual 10 per cent spoilage in 30-day-old, commercially-bought eggs. The cooks have enough faith in us to break our eggs directly into the frying pan. If extra eggs have to be purchased, you will find that our eggs are reserved for the kitchens that serve malts and other high protein diets.

Farm Financial Records Are Realistic

All produce goes to the storeroom where it is weighed, inspected and delivered to the dietitian, whose authority to refuse the product is unquestioned. In cases where the product is good but the quality is impaired, the price is cut sharply. The vegetables are weighed before they are cleaned and the waste is weighed and subtracted to determine the net weight. On more than one occasion, potatoes have been furnished to the hospital for three cents a pound when the wholesale price was ten cents. I'm sure there are occasions when the reverse is true, but certainly one will balance the other.

Our farm superintendent does not have enough influence to project unrealistic paper profits! A faithful record is kept of the farm expenditures and production. This results in an accurate account of the monetary value of the farm to the hospital. According to these records our farm was worth $75,678 to the hospital during the last fiscal year. It is difficult to estimate the economic value of the farm to the surrounding community. It provides jobs for the lower-income, part-time farmers; it often serves as an educational facility, providing a meeting place for pasture field-days, 4-H and FFA judging workouts. Our dairy farm leads the community in the breeding, exhibiting and production of dairy cattle. Many local farmers make periodic visits to look at our animals and seek advice applicable to their own farms. Our dairy farm is unquestionably the largest source of supply in the area for young Holstein herd sires.

Labor Is Never a Problem

Many hospital farms have been criticized for heavy capital expenditure on farm machinery and other equipment, to the detriment of the patients. Our farm is very conservative in spending the taxpayers' money. In terms of mechanization and capital outlay for the farm operations we are below many of the farms in our area. We use three teams of mules for spreading manure, daily feeding of cattle and gathering garden produce. This type of operation is cheap and can be carried out by patients with a small amount of supervision.

This leads us to a consideration of the therapeutic values of the farm operation. We have more patients working on the farm today than we had five years ago. Because the tenure of treatment is shorter, the patient-workers are of higher quality. Labor should never be a problem on the mental hospital farm, no matter how quickly the patients are discharged. The penal institutions have labor going to waste and are eager to lend-lease some of the more desirable of their inmates to the mental hospital farms. Our labor problem has never reached that point, but many of the other state institution farms operate very successfully in this manner.

Today the "new deal" in mental hospitals has opened the doors in an effort to get away from the prison atmosphere. As a result job assignments and supervised recreational activities are needed more than ever. The professional staff at our hospital feels that good job assignments and careful observation of the results are the only sure methods of determining how well a patient is able to accept responsibility, cooperate with his fellow men, and thus become fit to return to society. Busy hands doing simple but vital tasks sometimes help to untangle the confused minds of the mentally ill.

Farm Patients Have Esprit de Corps

The spirit of our 45 farm patients is high, probably because there is very careful supervision and their workday never exceeds seven hours. Each patient has one day off duty each week. Many patients will ask to work on their days off, and on numerous occasions patients have made an effort to cover up a minor physical illness so as not to be kept on the ward. Their spirit is exemplified by their willingness to work, their attitude toward their employee-supervisors and their pride in their work.

We have found farm assignments help to activate regressed patients. The withdrawn patient who sits in a dark corner of the ward, worrying about himself or the folks back home, is sometimes very reluctant to accept a job assignment. When he can be persuaded to work on the farm, a noticeable change will be seen within two or three days. The patient's coloring, appetite and attitude start to improve. His brighter eyes indicate a regained interest in life, and sometimes his attitude will change to the extent that he will actually express thanks for your influence in starting him to work. As the patient himself progresses, so also do the scope and responsibility of his work. The more capable patients sometimes help employees to supervise the less capable ones.

Several special and richly-deserved favors are given to the farm-working patients. An annual Christmas party, sponsored by the outside employees, is given for the farm patients only. These same employees recently bought and contributed a television set especially for this group of patients. Clothing donated to the hospital by various organizations is specially fitted to the working patients where possible. These small privileges tend to set the working patients apart from the others and help motivate them to work. Many realize that the farm is their proving ground. If they can get along with their fellow workers and learn to accept responsibility while doing their farm job, their chances of going home are good. We feel that work, wholesome fatigue and the satisfaction of a job well done have therapeutic value in the treatment of mental illness.

SPECIALIZING LUBRICATION

By LEWIS C. VAN HUBEN

Chief Engineer, Rockland State Hospital

Orangeburg, N.Y.

THE SYSTEMATIC LUBRICATION of mechanical equipment in mental hospitals is an essential factor in setting up an effective preventive maintenance program. Although hospital maintenance men have long realized this, they have not been so successful in applying the necessary methods to achieve it as have public utilities and private industries, primarily because of basic differences in the utilization of manpower. In industry the duties of the individual employee are not so widespread as in state civil service operations where "doubling in brass" is a common practice.

For instance, in a state hospital, a machinist assigned to repair food-preparation machinery may also be responsible for its periodic greasing and oil changes. Electricians who maintain elevators as part of their regular duties are also charged with the lubrication of elevator motors, hatchway trackage, sheaves, etc. Plumber-steamfitters detailed to repair heating and drainage systems are equally responsible for the lubrication of motor and steam turbine-driven condensate pumps, sump pumps, and vacuum pumps.

These are only a few of the many somewhat confusing combinations. And because of them mechanics do not have sufficient time for mechanical work and this in turn results in a constant backlog of unfinished repairs. In addition, these men, most of them in high pay grades, spend considerable time on lubrication that could be done just as efficiently by specialists drawn and trained from lower pay groups.

Furthermore, lubrication under this kind of set-up becomes a hit-or-miss affair, not done according to a schedule, but occurring usually when other maintenance work on the equipment is necessary. Consequently, some pieces of equipment are over-lubricated while others are starved and run dry. A mechanic may even substitute the wrong lubricant when he doesn't have the correct one with him, rather than make an extra trip or leave the machine out of service. Altogether this means failure in getting the full service and economy which lubrication should provide.

The remedy for this situation is a systematic, supervised lubrication program which stands by itself and not as a part of other maintenance activities. It should be specialized, with responsibility pinpointed in a minimum of personnel. Equally important is the keeping of accurate records.

Establishing such a program may take time at the start and require a lot of planning and effort but the end results should more than pay for the time expended.

Suggested Plan

The plan described below is based upon a similar one designed and set up by the writer several years ago for two public utility stations in Rochester, N. Y. Basically, it requires:

A. The training and equipping of one or more "Lubrication Specialists" (depending on the size of the plant) and assigning them to definite areas of responsibility.

B. Scheduling all equipment and lubrication points so they will be serviced at periodic intervals according to manufacturers' recommendations.

C. Setting up a card index containing all pertinent lubrication data for each piece of equipment.

In implementing this program, the steps outlined as follows can be performed in whatever order is dictated by conditions at the individual hospital.

Step 1. Make a survey of all equipment, collect all pertinent data, and transfer the information to a card index system like the one illustrated. The face of each card should be ruled in columns for the lubrication specialist's use. Column headings should be: Date; Quantity, Grade, and Name of lubricant used; Method of Application (oil can, grease gun, hand-change, etc.); Remarks; Initials; and Date of Next Application. The reverse side of the card should include: the name and purpose of equipment; manufacturer's name and address; serial, model, and type numbers; type, grade, and quantity of lubricant required; location of lubrication points and the recommended interval of servicing. Any special conditions such as heated rooms, wet locations, or outdoor operation, which would influence lubricants, should also be listed.

The cards should then be grouped according to areas, and filed in the index according to the calendar sequence of lubrication; for example, 1st week of each month, 2nd week, etc. Stagger the lubrication dates to prevent more than one large service job, such as changing oil in a compressor, from occurring on the same day.

Step 2. Select and train personnel as lubrication specialists. These may come from the labor force and should be stable, trustworthy and willing to accept responsibility. They can be trained in a series of talks which should cover:

Lubricants—Where and how they are manufactured, their purposes, storage and handling, and their relationship to reduced costs and maintenance.

Lubrication Methods—The use of lubricating equipment, servicing plain and movable bearings, and making oil changes.

Maintenance Records—How and why they are kept and their value in estimating the life of lubricants, bearings, and machinery.

Step 3. Equip a grease cart for each specialist. The one shown is made of lightweight angle iron and can be used to carry limited quantities of all lubricants used, oil cans, pumps, spouts, grease guns, and clean rags. It also has a small vise attached and a drawer, which can be locked, for tools and small parts.

Step 4. Lay out permanent areas of responsibility so that each man has a fair day's work but is not overloaded. Allow at least one free hour at the end of the day for replenishing the cart and filling out records.

The System at Work

Let's take the end of a hypothetical day. Assume that the specialist has already completed his assignments and has returned to base. He refills his portable containers from stock and enters the amounts on the oil record. After disposing of waste materials he cleans his grease guns and equipment in preparation for the next day. He rechecks the service entries on the cards which he has on the cart and returns the cards to their proper position in the file according to the next service date. Finally he removes the cards showing lubrications due the next day and arranges them according to their location, in order to save time and insure against skipping anything.

If, during the day, he has found any unusual condition that should be brought to the supervisor's attention, he makes out a written report. Also, if he has a job coming up the following day that will require extra help, he arranges for this help before going off duty.

The chief engineer or a designated person other than one of the specialists, inventories the card file at least once a month to make sure that all equipment is being properly serviced and that the file is being kept in order and up to date. He also inserts new cards and removes those which have been filled.

Conclusion

This system has already been tested over a period of years and it has proved that the following results can be obtained:

1. Better lubrication and less waste. 2. Longer bearing and equipment life. 3. The elimination of equipment outages caused by neglect or insufficient lubrication. 4. The prevention of material shortages through better inventories which enable orders to be made on the basis of anticipated needs. 5. Reduced backlog of repair work as a result of the increased use of mechanics in their assigned jobs.

The system is not foolproof, of course. Its success depends strongly on the human element involved, and even careful selection does not always produce the best man. However, he *can* be found.

LUBRICATION FILE CARD

KEY - O for OILED, G. for GUNNED, CC for COMPLETE CHANGE

DATE	MOTOR SHAFT AND BEARING COND.	PUMP LUBE NAME	PUMP QUAN. USED	PUMP SERV. DATA	PUMP RING COND.	REMARKS	INITIALS	NEXT SERVICE DATE
[illegible]	O.K.	[illegible]	[illegible]	C.C.	Good		M.H.H.	[illegible]
[illegible]	O.K.	[illegible]	[illegible]	O	"	[illegible]	M.H.H.	"
[illegible]	O.K.	—	—	—	O.K.	[illegible] O.K.	M.H.H.	"
[illegible]	O.K.	Aredden [illegible]	[illegible]	C.C.	[illegible]	[illegible]	M.H.H.	[illegible]
[illegible]	O.K.	— [illegible]	—	—	"	[illegible]	M.H.H.	"

Face Side

ITEM - No. 2 BOILER FEED PUMP. FEEDS WATER TO BOILERS.
LOCATION - Feedwater treatment and control room. Boiler house annex.
MANUFACTURER - MOTOR: Northwestern Mfg.Co. Milwaukee, Wisconsin PUMP: Frederick Iron & Steel Co. Frederick, Maryland

MOTOR DATA

Serial-71198 Type-HW 75
Horsepower 100
Volts-2200 Amps-13 @ no load
" 24.7 @ 100HP rating
Phase 3, Cycles 60, RPM 1750

Lubrication required -
Bearings are sealed life-time guarantee.

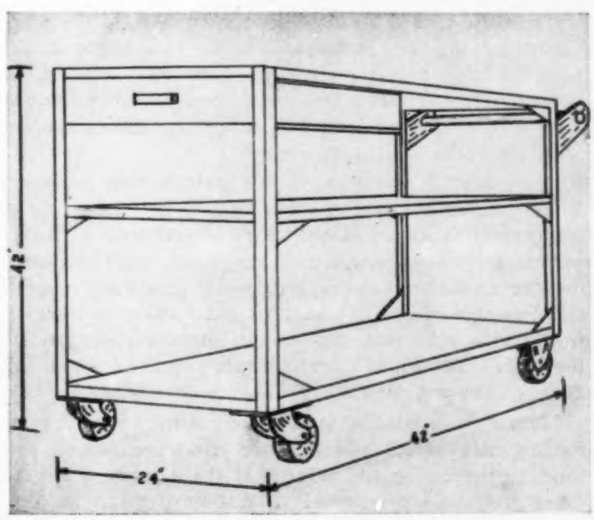
SERVICE DATA: Check bearings for noisiness and shaft in motor for evidence of loss of clearance on rotor windings indicating bearing wear EVERY TIME the pump end is serviced.

PUMP DATA

Serial - 2004 Size 5
Type - D.S.V.-L
Capacity - 1000 GPM.
RPM 1750
Discharge head - 225 ft.
Lubrication required - (Tidewater) Engine Oil
Kind - Gen. eng. Grade - Med. Type Aredden No. 57
Lube. points - Ring oiled sleeve bearings at each end of pump shaft.
Quantity Req. - 1 qt. each bearing.
Frequency - Complete change every 3 months. Check for level monthly. Add as necessary.

NOTE: On every service call, check oil rings for freedom of travel, breakage and/or wear.

Reverse Side



LUBRICATION SUPPLY CART SPECIFICATIONS

Framing—1" x 1" x 3/16" angle iron.
Shelving—galvanized sheets or masonite.
Corner Gussets—⅛" steel sheet 2" x 2" bases.
Drawer of sheet metal, 24" wide, 16" long, 6" deep.
Casters—2 movable, 2 fixed. Ball bearings.
Handle—¾" pipe.
All joints welded.

Food Service is a Business Administration Operation!

By C. P. O'CONNELL, *Business Manager*
Middletown State Homeopathic Hospital, N. Y.

ANY BUSINESS MANAGER worthy of the name, faced with the opportunity of getting rid of a sizable responsibility, a great many headaches and innumerable hours of good hard work, would grab at the chance with his two grubby fists!

If it were proposed to me, for example, that henceforth the nutrition services of my institution should become the responsibility of say, the assistant director (clinical), my first reaction would be one of unalloyed joy. I would be freed of directing the activities of a department employing 155 people who buy and prepare $733,000 worth of food a year. It couldn't happen to a nicer guy!

After I had leafed through the third Mediterranean cruise folder—I would have so much time to travel—some of the realities of the situation would begin to filter through. How would the supervising dietitian go about planning the meals for 3,500 patients? What budgeting advice would be available to her? Would the farm produce artichokes and strawberries, but no corn and peas? Would requirement lists bear any relation to inventories? Would the costly equipment—counters, dishwashers, steamers, refrigerators, etc.—be maintained properly?

Regretfully I would have to conclude that my good friend, the assistant director (clinical), presently coping competently and resolutely with his problems of direct patient treatment, would make a valiant stab at directing the nutrition services, but would gradually enmesh the business office in a sort of dual operation which would satisfy no one, and would ultimately demoralize the highly important dietetic service, to the great detriment of the patients.

Mental hospitals, at least public ones, require mass feeding techniques, which range from purchasing raw food to preparing and serving it three times a day to large groups of people. (It is not uncommon in New York State, for instance, to serve 10,000 patients three meals a day.) If a nutritionally adequate diet regime is developed and made available to the hospital population as a whole, as is being done for New York State's 27 institutions, it seems logical to turn over the administration of this operation to the dietitian and food service manager. With the direction and assistance of the business (non-medical) administrator, these professionally-trained personnel are then able to translate the basic food plan into the many detailed functions and operations which will ensure that every patient is served attractive, appetizing and nutritionally sound meals, three times a day, every day of the year.

Let us illustrate the close relationship of the food service to the business office. A year or so ago, our state institutions changed from the use of carcass beef to processed frozen beef cuts. Our food plan had been nicely calculated on the use of carcass beef, considering such variables as percentages for patients, employees and staff, and the non-edible portions of fat, bones and so forth.

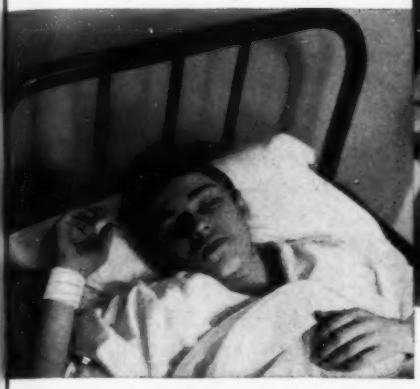
The new frozen cuts introduced a tricky conversion factor to ensure that our actual consumable meat would be approximately the same. Other problems involved storage and issue of the new type of meat, as well as preparation of it. Here was a non-medical problem in administration, if there ever was one! Similar problems arise almost daily, as any dietitian will tell you, and can be worked out best through direct communication between the nutrition service and the business office. (Unless you wish to argue that the clinical director should devote some of his therapy time to giving therapy to the dietitian!)

Another compelling reason for the dietitians to work under the "non-medical side of the house" are the payroll statistics. These will show, for instance, that the salaries of the food service personnel are less than the cost of the food consumed, whereas the dollar ratio of ward service salaries to consumable bed-care supplies (drugs, linens, etc.) is substantially greater. Since the cost of patient care by professional and subprofessional personnel greatly outweighs the cost of incidental expenses, there is a clear case here for medical administration and direction. But in the food service, where the food costs over-balance personnel costs, expert administrative (non-medical) supervision is called for. In the field of purchasing alone, the food service in a public mental hospital is "big business."

Few Therapeutic Diets in Mental Hospitals

A case is sometimes made for medical administration of the food service on the grounds of therapeutic diets. But in a mental hospital, such diets are needed for relatively few patients, most of whom are in the medical and surgical or infirmary buildings. These diets are, of course, prescribed by a physician and prepared accordingly. However, these therapeutic diets, the direct responsibility of the dietitian, are so designed that they become modifications of the basic dietary, rather than complete departures therefrom. The production of the basic dietary, nutritionally sound and medically acceptable, with needed therapeutic variations, is the aim toward which the entire complex operation of the food service is directed.

I would like to add a closing word in praise of the nutrition service personnel. In a field which is constantly open to criticism, constructive and otherwise, they operate efficiently, conscientiously and cheerfully, and to a large extent, unhonored and unsung. It is a pleasure to be associated with them.



MARCH 4, 10:00 A.M.
SPARINE, I.V., has been given.
Patient in light sleep.
Can be awakened readily,
and responds to questioning.

MARCH 5, 2:00 P.M.
Receiving oral SPARINE.
Quiet but alert. Contrite
about smashed window.

MARCH 8, 9:00 A.M.
Still on oral
SPARINE, maintenance
dosage. Ready
for psychotherapy.

SPARINE quickly controls acute psychotic episodes, then maintains control while definitive psychiatric treatment is provided. SPARINE facilitates accessibility, speeds rehabilitation, simplifies care.

SPARINE acts most rapidly by intravenous injection; for effective maintenance, the oral or intramuscular route is usually used. It is well tolerated in all three methods of administration. *Comprehensive literature supplied upon request.*

Sparine® HYDROCHLORIDE
Promazine Hydrochloride, Wyeth

INJECTION TABLETS SYRUP

Wyeth®
Philadelphia 1, Pa.

More C.I.B. Approvals

At its April 27 meeting in Philadelphia, the A.P.A. Central Inspection Board officially approved another 10 private psychiatric hospitals. Private psychiatric hospitals fully approved by the C.I.B. now total 22, in addition to the 22 state, federal and provincial hospitals previously unconditionally approved.

For a private psychiatric hospital to obtain approval, it must score 80 per cent or more for each department on the essential list, with a general over-all average of 80 per cent. The essential departments are: administration; physical plant; medical staff organization; medical records; nursing service; psychiatric treatments and medical services.

The 10 private hospitals recently approved by the Board are: Clinique Roy-Rousseau, Quebec; Hall-Brooke, Westport, Conn.; Four Winds, Katonah, N. Y.; Falkirk Hospital, Central Valley, N.Y.; Brawner's Sanitarium, Smyrna, Georgia; Anclote Manor, Tarpon Springs, Florida; St. Albans Psychiatric Hospital, Radford, Virginia; Tucker Hospital and Westbrook Sanatorium, both in Richmond, Virginia; and Appalachian Hall, Asheville, North Carolina.

For complete lists of other hospitals, approved or conditionally approved, see MENTAL HOSPITALS, June and December, 1958.

Fourth Design Clinic Held

"Psychiatry for Architects" was the theme of the Fourth A.P.A. Design Clinic held on May 14, 15 and 16, in the A.P.A. Central Office in Washington, D. C. Because of the need of some of the architects for individual evaluation of their plans, the number attending this clinic was sharply limited.

Members of the Faculty included Charles E. Goshen, M.D., of the staff of the A.P.A. Architectural Service; Charles K. Bush, M.D., Chief Inspector, A.P.A. Central Inspection Board; Mr. Wilbur R. Taylor, Division of Hospital and Medical Facilities, U.S. Public Health Service; Mr. Eric Pawley, A.I.A. of Washington, D.C.; Alston G. Guttersen, A.I.A. of Washington, D.C.; Humphry Osmond, M.D., of Saskatchewan, Canada; and Mr. Colin McLean, a furniture designer, of Chicago, Illinois.

The program consisted of informal lectures, demonstrations and seminar discussions. The lectures included information on the type of psychiatric data needed by architects designing mental hospitals; the policies and procedures of the Hill-Burton Hospital Construction Program; and, most popular of all, a lecture followed by a discussion on "Developing the Program" during which such problems as architect-client communications, psychiatric treatment principles in relation to construction, need for flexibility of function and for long-range planning, were explored.

The program closed with discussions on the interpretation of the psychiatric program into architectural expression, the influence of design on function, and the importance in psychiatric care, of such environmental details as decoration, color, furnishings and outdoor facilities.

Architects attending were: Mr. John Ahlers, of Baltimore, representing the State Department of Mental Hygiene; Mr. Hugh Meriwether, of Lexington, Ky., representing Meriwether, Marye and Associates; Mr. Walter W. Hook, of Charlotte, North Carolina; Mr. Ralph O. Yeager, Jr., of Terre Haute, Indiana, whose firm is working on the Logansport State Hospital; and Lt. Gerald F. Oudens, representing the office of the Surgeon General, Facilities Division. Mr. Roger C. Mellem, of the American Hospital Association, attended as an observer.

READERS' FORUM

Back Issues of MENTAL HOSPITALS Wanted

I have been working on my library and have all the published issues of MENTAL HOSPITALS beginning with Volume III. I am now looking for issues from Volumes I and II. Do you know of any that are available, or of anyone who has copies of any or all issues from these two Volumes (1950 and 1951) and would be willing to sell them to me? If they can be obtained in any way, I would very much like to complete our library set.

Martha Gibson, New Castle State Hospital, P.O. Box 34, New Castle, Indiana.

A Plug for The Hospital Farm *

I have seen a number of articles in different magazines, and one in your journal, that were opposed to farms in connection with state mental hospitals. We feel that no one hospital should have the attitude that because farming is not suitable to its community, it follows that no other hospital should have a farm.

We at this hospital have been and are very proud of our farming activities and we believe there is no question but what they are of great value to us.

P. L. Hays, M.D., Medical Superintendent, Eastern State Hospital, Vinita, Oklahoma

Patient Help in Laundries

The very interesting and constructive article by Thomas Summers in the December 1958 MENTAL HOSPITALS indicates a fine understanding and detailed knowledge of mental hospital laundry administration.

There should be no difference of opinion on the two premises that employment of mental patients in an institutional laundry should be part of a definite "preplanned rehabilitation program" and that advantages are more likely to be evident if such a program of therapy is "directed" and coordinated by an industrial therapy program.

In Pennsylvania there is marked evidence indicating increasing numbers of patients participating in the industrial therapy program. Several superintendents of mental hospitals have recently stated that the rehabilitative opportunity in laundry employment has been clearly demonstrated.

This attitude is no doubt due to at least the following factors inherent in the laundry program:

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* *See "The Value of The Mental Hospital Farm"– Page 43.*

A stable organization and an assured program operating 5 or 5½ days, week after week, year in and year out.

A responsible head of the department with additional paid employees who can be drawn upon for supervision.

Containment of the work program in one structure and under conditions favorable to patients, regardless of outside weather.

A location which is readily available to patient buildings.

More than 1500 patients are employed in seventeen mental hospitals in this state. The ratio of patients so employed to paid employees is approximately 5:1. The range from institution to institution is wide. It is interesting to note that where the range is greater than the average figure given, there is a high correlation with the quality of work performed, as measured by test bundle analysis, reports on breaking strength loss, whiteness retention, and soil removal. It is probable that this correlation is not due so much to the larger number of patients employed as to over-all administrative policies which tend not only to better care for patients but also to encouragement of better performance by paid employees. The trend as to patient employment seems to be upward as to number of patients, and downward as to length of time assigned.

R. Bruce Dunlap, Director, Mental Health Construction & Maintenance, Pa. Dept. of Welfare, Harrisburg.

NEW PRODUCT

A GIANT STEP AGAINST STAPHYLOCOCCUS

With staphylococcus infection reaching a new high in hospitals, the progressive institution is taking every precaution to develop preventive measures.

A unique product, the Solareum O-Rvershoe, manufactured by A. G. Verdolyack, Inc., Kalamazoo, Michigan, is designed to close the loophole which permits the infection to be borne throughout the hospital on the shoes of operating-room personnel. In addition, the O-Rvershoe helps to protect the wearer himself from falling victim to staphylococcus.

In order to meet electrostaticity specifications, it was important that the foot covering be conductive, grounding the wearer to avoid the possibility of explosion. A special conductive sole was devised with an inside tab of the same conductive material, to be inserted under the foot inside the wearer's own shoes.

The upper portion of the O-Rvershoe is made of DuraWeve, a product of Scott Paper Co., and consists of two layers of cellulose bonded to a rayon screen. The shoes are thirteen inches high and come in sizes Small, Medium or Large. They are secured around the ankles by means of a plastic tie.

Ideal for use by visiting surgeons and in teaching hospitals, O-Rvershoes used in non-infectious situations can be autoclaved for re-use. Many of the major hospitals have adopted them as standard equipment for operating rooms in an effort to cut down the infection hazard from not-often-cleaned shoes. Orthopedic plaster rooms have also found a use for the boots to end tracking plaster into corridors and other rooms.

The Department of the Army is currently field testing O-Rvershoes and several of the Veterans Administration hospitals have already adopted it.

ALEXIS TARUMIANZ

FILM REVIEWS

THE TWO ACCOMPANYING PHOTOGRAPHS are stills from the newest acquisitions of the A.P.A. Mental Hospital Service Film Library. Detailed reviews appeared in the April 1959 issue of MENTAL HOSPITALS, pages 23 and 24.

Old friends of the A.P.A. and the M.H.S. will be pleased to recognize the woman professor in the still from THE FEELING OF HOSTILITY as Miss Elsie C. Ogilvie, R.N., former A.P.A. Nursing Consultant, now associated with the University of Toronto School of Nursing. The film was produced by the National Film Board of Canada.

In the above scene from THE FEELING OF HOSTILITY, the main character, Clare, discusses her problems of emotional inadequacy with a woman professor who befriends her at college.

Susan Burke, a young public health nurse in BROKEN APPOINTMENT, gets a cool reception from a patient she visits to find out why the patient failed to come for her check-up.

PATIENT ART ADORNS A.P.A. CENTRAL OFFICE

One of the most unusual collections of paintings in the nation is now on exhibition in the Central Office of the American Psychiatric Association in Washington, D. C.

Entirely the work of psychiatric patients in art therapy clinics of Veterans Administration hospitals, the 24 paintings were chosen by James McLaughlin, curator of the Phillips Gallery in Washington. Most are of outstanding quality as art, he said.

To the psychiatrist, each tells a story of the man or woman who painted it, but little of this reflection of emotional turmoil or progress toward recovery is apparent to others.

Mostly oils and watercolors, the paintings range in subject matter from a portrait of President Eisenhower to still lifes of flowers and fruit, outdoor scenes, and abstractions.

"These paintings reflect great originality, imagination, and skill," Mr. McLaughlin said, adding:

"The collection undoubtedly would be rated highly in any showing of amateur art."

Painting is used as an aid in treat-

ment of mental patients at many Veterans Administration hospitals. It gives them a simple means of self-expression with consequent release from built-up tensions.

To all appearances, the hospital art clinics are easy-going, pleasant hobby groups, but beneath the surface there is a great deal of planning and control by the medical staff.

Patients are allowed to come in, sit down, and draw or paint at such times as they wish, and to choose their own subject, style of painting, and colors. Instructors are there to help and encourage.

The doctors are interested not only in the progress of the patient in the task of painting a picture but in the clues they can get from it as to how he is improving and what is going on in his mind.

The 24 paintings from VA Hospitals at Montrose, N. Y., Palo Alto, Calif., Perry Point, Md., and Topeka, Kan., were secured for the A.P.A. by J. F. Casey, M.D., Director P. and N. Service, VA Central Office.

New M.H.S. Consultants

The A.P.A. Mental Hospital Service is happy to welcome three new consultants who have just joined its Board—Dr. Hayden Donahue of Oklahoma, Mr. Sidney Spector, now of Washington, D.C., and Mr. Carl Yopp of Arkansas, all three of whom are long-time friends and supporters of the Service.

The staff would also like to add its thanks to those of President William Malamud to the three rotating off the Board this year: Dr. Addison M. Duval, who has been on the Board since 1949; Mr. Bruce Dunlap of Pennsylvania and Mr. Robert H. Klein of Chicago, both of whom have been consultants since 1954.

Dr. Alfred Stanton, the chairman of the A.P.A. Section on Mental Hospitals for the 1959 Annual Meeting, has served on the Board for the past year, and will be succeeded by Dr. Alfred Paul Bay, the 1960 chairman.

The Board also loses another old friend and consultant, Dr. Harvey J. Tompkins, with his resignation as chairman of the A.P.A. Committee on Standards and Policies of Hospitals and Clinics. Dr. Tompkins has the unique distinction of having served as Acting Medical Director of A.P.A. and Acting Editor of MENTAL HOSPITALS for three months during 1954.

Dr. Stewart T. Ginsberg, Commissioner of Indiana, but better-known to the staff as the man who found out the facts about volunteer programs during the Conference on Volunteer Services to Psychiatric Patients during 1957-58, assumes Dr. Tompkins' responsibility as chairman of the Committee on Standards and Policies, and becomes an ex-officio member of the M.H.S. Board of Consultants.

State Commissioners Form National Organization

By a unanimous vote, mental health commissioners and their equivalents from 34 states have voted to form a national organization, to be known as the National Association of State Mental Health Program Directors.

The organization is to incorporate as a non-profit association under the laws of the District of Columbia. Its first annual meeting will be held on Monday, October 19 in Buffalo, New

York, during the 11th Mental Hospital Institute.

The slate of officers voted in are: Dr. George W. Jackson, Kansas, President; Dr. Clifton T. Perkins, Maryland, Vice-President; and Dr. Harold McPheeters, Kentucky, Secretary-Treasurer.

Three members-at-large—Dr. John B. K. Smith, Alaska, Dr. V. Terrell Davis, New Jersey, and Dr. Dale C. Cameron, Minnesota, were elected to the Executive Committee. The Executive Committee will be responsible for the program of its annual meetings. The A.P.A. Mental Hospital Service is to serve as secretariat to the new organization.

Certification Committee Examines Hospital Administrators

Under the continued chairmanship of Dr. Winfred Overholser, the A.P.A. Committee on Certification of Mental Hospital Administrators met during the 115th Annual Meeting of the A.P.A. at Philadelphia and certified 26 applicants on their credentials. Another 18 were certified by examination, two were failed and one granted conditional certification.

A cumulative total of 547 psychiatrists have now been certified by the Committee, 81 by examination and the rest on their credentials. Since July 1, 1959, is the cut-off date for the so-called grandfather clause, there will be very few certified except by examination at the next meeting of the Certification Committee which will take place immediately before the 1960 Annual Meeting at Atlantic City.

Dr. Francis J. O'Neill will continue to be the secretary of the Committee, the other members of which are: Dr. George W. Jackson, Dr. Cecil L. Wittson, Dr. William B. Terhune, Dr. Harold Sterling, and Dr. Malcolm J. Farrell.

Opinion Study Planned on Remotivation

The present plans of the A.P.A.-Smith Kline & French Foundation Remotivation Project call for follow-up visits to hospitals which have already been visited by a training team, in order to develop an opinion study on the value of the techniques of Remotivation. This was decided during a meeting of the Executive Committee of the Project held in Philadelphia on April 26, 1959.

The Executive Committee's report indicated that 33 hospitals have been visited by the Remotivation Training Team and that 113 additional hospitals have sent personnel to attend the courses. A total of 700 people, including 175 nurses, 460 aides and 65 other personnel have participated as students. Much larger numbers of people observed the courses and attended orientation sessions.

The main burden of training has been the responsibility of Mrs. Mertell Cameron, R.N., and Mr. Walter Pullinger, a psychiatric aide, both from Philadelphia State Hospital. Other nurses and aides from the same hospital have also done outstanding work on training teams. Dr. Eugene Sielke, superintendent, and Miss Helen Edgar, director of nursing, are to be highly commended for providing the best of their personnel for these training teams.

More than 3500 manuals on the Remotivation Technique have been distributed, and the film "Remotivation: A New Technique for the Psychiatric Aide" has been seen by about 18,500 people.

PEOPLE & PLACES

HERE & THERE: **Lynn S. Beals, Jr., M.D.,** has been named executive director of the Massachusetts Association for Mental Health, Inc. Dr. Beals, who has just completed 24 years in the Navy; recently served as chief of neuropsychiatry at the U.S. Naval Hospital, in Chelsea, Mass.

On July 1, **Jackson A. Smith, M.D.,** formerly professor of psychiatry at the University of Nebraska and associate director for research at the Nebraska Psychiatric Institute, Omaha, will become clinical director at Illinois State Psychiatric Institute in Chicago.

Colonel Inez Haynes, retiring chief of the Army Nurse Corps, has been appointed as general director of the National League for Nursing. She will join NLN on September 1, succeeding **Miss Anna Fillmore** who be-

came executive director of the Visiting Nurse Service of New York on June 1.

Mr. Warren J. Lenz, the administrator of Central State Hospital in Kentucky, has resigned his position to become assistant administrator of St. Luke's Hospital in New Bedford, Mass. **Mr. William L. Shepherd** is his successor.

Joseph B. Parker, Jr., M.D., until recently on the faculty of Duke University Medical Center, Durham, N.C., will take up his duties as professor and chairman of the department of psychiatry at Kentucky's new medical center, Lexington, sometime during the summer.

Else B. Kris, M.D., professor of social psychiatry at Adelphi College and principal research scientist at the research unit of the Manhattan Aftercare Clinic, N.Y., has received a three-year grant from the National Institute of Mental Health. She will study intensive short-term therapy in a day-care facility for prevention of rehospitalization. This study will be conducted in a newly established day-care center connected with the research unit. In addition to psychiatric nursing and O.T. services, the center will provide limited vocational training and recreational facilities.

In a ceremony that took place on May 2 at the New York Academy of Medicine in New York City, **Dr. Herman B. Snow** of Ogdensburg, N. Y. received one of the Adolf Meyer Memorial awards for his "outstanding work as director of St. Lawrence State Hospital in respect to the development of the open door policy." The awards are given annually by the Association for Improvement of Mental Health, Inc., to individuals who have made meritorious contributions to the professional care and treatment of the mentally ill, both in and outside of hospitals.

FLASH! The new medical center, to operate in conjunction with the Hospital for the Mentally Retarded in Stockley, Delaware, is to be named "The Dr. M. A. Tarumianz Medical Center." The dedication ceremony takes place on June 11, and will be attended by many of the A.P.A. Central Office staff who want to pay tribute to a friend of long-standing. Dr. "T" has been Chairman of the Central Inspection Board since 1947 and an M.H.S. Consultant since the Service was founded in 1949. Our only regret is that the new Medical Center is not a "T"-shaped building!

HAVE YOU HEARD?

COMMUNITY SERVICES: When the Legislature established day-care centers in 1957, **Delaware** became the first state in the country to provide a training program for severely retarded children from 3 to 21 years old. This state-wide program is completely supported by state funds and operated under state control. By June 1958, four centers were in operation in different localities with an enrollment varying from four at Seaford, to twenty at Wilmington. The centers operate from 9 a.m. to 3 p.m. Aides assist the children in developing independent action and skills. Training is given in personal cleanliness and self-feeding. At Wilmington, the staff is assisted at mealtimes by volunteers.

Probably the most outstanding

QUARTERLY HOSPITAL PROFESSIONAL CALENDAR

A.P.A. ANNUAL MEETING

1960 May 9-13, Convention Hall, Atlantic City, N. J.

1961 May 7-12, Hotel Morrison, Chicago, Ill.

1962 May 6-11, Queen Elizabeth Hotel, Montreal, Canada

1963 May 12-17, Ambassador Hotel, Los Angeles, Calif.

A.P.A. MENTAL HOSPITAL INSTITUTE

1959 Oct. 19-22, Hotel Statler, Buffalo
Oct. 19, Special Sectional Meetings
Oct. 20-22, Plenary Sessions

1960 Oct. 17-20, Hotel Utah, Salt Lake City

1961 Oct. 23-26, Hotel Fontenelle, Omaha

Other Meetings, September, October, November, 1959:

A.P.A. Western Divisional Meeting, Sept. 24-27, Seattle, Wash. (Inq.: C. H. Jones, M.D., Northern State Hospital, Sedro-Woolley, Wash.)

American Occupational Therapy Association, Annual Conference, October, Chicago, Ill. (Inq.: Amer. O. T. Assoc., 250 W. 57th Street, New York 19, N. Y.)

Council of State Governments, National Legislative Conference, Oct. 6-9, Hotel Cosmopolitan, Denver, Colo.

Council of State Governments, Southern Governors' Conference, Oct. 11-14, Grove Park Inn, Asheville, N. C.

Academy of Psychosomatic Medicine, Oct. 15-17, Cleveland, Ohio.

National Association of State Mental Health Program Directors, Oct. 19, Hotel Statler, Buffalo, N. Y.

National Association for Retarded Children, Annual Convention, Oct. 21-24, Cincinnati, Ohio.

National Association of Private Psychiatric Hospitals, Oct. 23-24, Hotel Statler, Buffalo, N. Y.

American Medical Association—Conference of Mental Health Representatives of the State Medical Associations, November. Inq.: Richard J. Plunkett, M.D., A.M.A. Council on Mental Health, 535 N. Dearborn St., Chicago 10, Ill.)

Group for the Advancement of Psychiatry, Nov. 5-8, Hotel Vanderbilt, New York, N. Y.

A.P.A. Divisional Meeting, Nov. 13-15, Hotel Biltmore, New York, N. Y.

National Association for Mental Health, Annual Meeting, Nov. 17-20, Philadelphia, Pa.

achievement of this program is the improvement in the social relationships of these children with other youngsters and with the training aides.

Fair Oaks Hospital, Summit, N. J., has entered its sixth year of providing 365 patient-days a year of free care as a community service. To date forty-five persons referred by county welfare and family agencies have been given treatment by this service. Patients need not be completely indigent but are people who cannot afford lengthy hospitalization in a private psychiatric hospital. Only the medical director, Dr. Oscar Rozett, and the administrator, Mr. Thomas Prout, Jr., know which patients are receiving free treatment. Their care, of course, in no way differs from that provided to all other patients.

EX-PATIENT CLUB: At the **Owen Clinic,** a non-profit psychiatric hospital in **Huntington, W. Va.,** ex-patients and members of patients' families have formed a club to aid newly discharged patients and their relatives in their adjustment to community living. To combat the stigma attached to mental illness and hospitalization, these former patients appear as panelists at civic meetings and on radio and television. Reports indicate that forthright, knowledgeable statements by Owen Club members are very convincing. One result: with only one exception, all club members have been accepted whenever they have applied for jobs after discharge.

CONSTRUCTION: On April 2, Governor Stratton of Illinois broke ground for the new $4.5 million **State Pediatric Institute for Mentally Retarded Children** in Chicago's West Side Medical Center. Expected to be completed in two years, this 585-bed institution will serve youngsters under the age of six. The seven-story hospital has been designed specifically as a research institution with facilities for training medical and other personnel. Each of the six patient-care floors will have six ward rooms. The fifth floor isolation department is designed for one five-crib ward and several single-crib rooms. Plans also provide for classrooms, examination and conference rooms, a play therapy area, a recreational and education therapy room, and a psychological research and observation area.

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